Operations, Maintenance, and Enhancements for OCSS Systems

Electronic National Medical Support Notice

Appendix E

Software Interface Specification

Version 1.6

August 23, 2023

Administration for Children and Families
Office of Child Support Services
330 C Street SW, 5th Floor
Washington, DC 20201

Operations, Maintenance, and Enhancements for OCSS Systems
Electronic National Medical Support Notice
OMB Control Number: 1970-0222

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Revision History

Date	Revision	Section	Author
3/29/2021	v1.0: Original release	Entire document	H. Rallapalli
6/29/2021	v1.1: Minor updates	Chart E-2: Updated the following fields: • Other Coverage Type Description • Other Insurance Provider Name	H. Rallapalli
8/18/2021	v1.2: Minor updates	Changed .PDF to.pdf in all locations with sample filenames Chart E-2: Updated the following fields: • Medical Insurance Policy Number • Dental Insurance Policy Number • Vision Insurance Policy Number • Prescription Drug Insurance Policy Number • Mental Health Insurance Policy Number • Other Insurance Policy Number	H. Rallapalli
1/31/2022	v1.3: Minor updates	Chart E-2: Updated the length of the following fields: • Medical Insurance Provider Name • Medical Insurance Group Number • Dental Insurance Provider Name • Dental Insurance Group Number • Vision Insurance Provider Name • Vision Insurance Group Number • Prescription Drug Insurance Provider Name • Prescription Drug Insurance Group Number • Mental Health Insurance Provider Name • Mental Health Insurance Group Number • Other Insurance Provider Name • Other Insurance Group Number	H. Rallapalli
4/20/2022	v1.4: Minor Updates		M. Stanczyk
1/27/2023	v1.5: Split document body and appendices into separate files	Entire document	J. Vierow

8/23/2023	V1.6: Field changes	Chart E-1: The Filler field length increased and the location changed.
		Chart E-2: The following changes were made:
		• The following fields were added:
		  o Ineligible Child 7 Last Name
		  o Ineligible Child 7 First Name
		  o Ineligible Child 7 Middle Name or Initial
			M. Stanczyk

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Date	Revision	Section	Author
		- o Ineligible Child 7 Suffix Text - o Ineligible Child 7 Gender - o Ineligible Child 7 Date of Birth - o Ineligible Child 7 Social Security Number - o Ineligible Child 8 Last Name - o Ineligible Child 8 First Name - o Ineligible Child 8 Middle Name or Initial - o Ineligible Child 8 Suffix Text - o Ineligible Child 8 Gender - o Ineligible Child 8 Date of Birth - o Ineligible Child 8 Social Security Number - o Plan Administrator or Representative Email Address - o Medical Effective Date of Coverage - o Medical Phone Number for Claims - o Dental Effective Date of Coverage - o Dental Phone Number for Claims - o Vision Effective Date of Coverage - o Vision Phone Number for Claims - o Prescription Effective Date of Coverage - o Prescription Phone Number for Claims - o Mental Insurance Effective Date of Coverage - o Mental Phone Number for Claims - o Other Insurance Effective Date of Coverage - o Other Phone Number for Claims - The Filler field length increased and the location changed. - Field locations were updated because of the added fields. Chart E-3: The Filler field length increased and the location changed.	

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List of Charts

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E   Electronic Part-B Response Record Layouts

Chart   E -1 contains the Electronic Part-B Response Header Record layout.

No.	Field Name	Length	Location	A/N	Comments
	Chart E-1: Electronic Part-B Response Header Record Layout				
1	Record Identifier	4	1–4	A	Required. The letters BRFH, which identify the record as a Part-B Response header.
2	Employer FEIN	9	5–13	N	Required. The employer's FEIN where the NMSN order was sent initially.
3	Third-party FEIN	9	14–22	N	Conditionally required; must be filled if the third-party provider is responding to Part-A and Part-B. The FEIN of the third-party provider responding to both Part-A and Part-B.
4	Plan Administrator FEIN	9	23–31	N	Conditionally required. The FEIN of the third-party plan administrator processing only a Part-B response for an employer.
5	FIPS Code	2	32–33	N	Required. The two-digit locator code of the requesting state.
6	Processing Date	8	34–41	N	Required. The date the header was generated. Must be in CCYYMMDD format.
7	Creation Time	6	42–47	N	Required. The time the header was generated. Must be in HHMMSS format.
8	Batch ID	6	48–53	A/N	Required. A unique identifier for each batch sent to the Portal daily. Use the unique batch ID only once per day. Left-justified and padded with spaces to the right.

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No.	Field Name	Length	Location	A/N	Comments
	Chart E-1: Electronic Part-B Response Header Record Layout				
9	Portal Error Code(s)	49	54–102	A/N	For Portal use. Generated when the Portal performed its validation and found errors. Header records with errors return the entire batch. The returned batch contains all the responses originally sent. Valid values: DRVF – Detail Record Validation Failed DBCN – Duplicate Batch Control Number BHCR – Invalid data in a conditionally-required field SPDE – State Profile Does Not Exist EPDE – Employer Profile Does Not Exist BHRF – Required field validation error Each code is separated by a comma. Left-justified and padded with spaces to the right.
10	Filler	2804	103–2906	A/N	This is for future versions. For this version, fill with spaces.

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Error: Reference source not found contains the Electronic Part-B Response Detail Record layout.

Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Record Identifier	4	1–4	A	Required. The letters BRFD, which identify the record as a Part-B Response Detail record.
Notice Date	8	5–12	N	Required. The date the NMSN was generated by the state. Must be in CCYYMMDD format. Must be returned by the employer, third-party provider, and plan administrator in the response.
CSE Agency Case Identifier	15	13–27	A/N	Required. The value assigned by a state to uniquely identify each IV-D case in the state. Must be returned by the employer, third-party provider, and plan administrator in the response.
Order Identifier	30	28–57	A/N	Conditionally required. A unique identifier associated with a specific child support obligation in a case. Must be returned by the employer or third-party provider in the response if the order identifier is sent in the request file.
Document Tracking Identifier	30	58–87	A/N	Required. A unique number that assists in tracking a notice through its complete "round trip" from the state to the employer or third-party provider and the plan administrator back to the state. Must be returned by the employer, third-party provider, and plan administrator in the response.
Notice Received Date	8	88–95	N	Required. The date when the notice was received by the plan administrator of an in-house employer or a third-party provider. Must be in CCYYMMDD format.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Qualified Medical Child Support Order Determination Code	2	96–97	N	Optional. Indicates the order is a qualified medical child support order. Valid value: 01 – This notice was determined to be a qualified medical child support order. Either the Qualified Medical Child Support Order Indicator field or the Not Qualified Medical Child Support Order Indicator field is required.
Qualified Medical Child Support Order Determination Date	8	98–105	N	Conditionally required; must be filled if the Qualified Medical Child Support Order Determination Code field is 01. The date when the notice is determined to be a qualified medical support order. Must be in CCYYMMDD format.
Coverage Response Code	2	106–107	N	Conditionally required; must be filled if the Qualified Medical Child Support Order Determination Code field is 01. Indicates whether the response will have coverage details for insurance or data for multiple options. Valid values: 02 – The participant (employee) and alternate recipients (children) are to be enrolled in the family coverage. 03 – Multiple options are available for insurance. 04 – Waiting period indicator.
Family Coverage Enrollment Indicator Type	2	108–109	N	Conditionally required; must be filled if the Coverage Response Code field is 02. Indicates the type of family coverage the children will be enrolled in. Types of family coverage. Valid values: 01 – The children are currently enrolled in the plan as a dependent of the participant. 02 – There is only one type of coverage provided under the plan. The children are included as dependents of the participant under the plan. 03 – The participant is enrolled in an option providing dependent coverage, and the children will be enrolled in the same option. 04 – The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Coverage Effective Date	8	110–117	N	Conditionally required; must be filled if the Coverage Response Code field is 02. The date when the medical coverage becomes effective. Must be in CCYYMMDD format.
Plan Summary Description Text	160	118–277	A/N	Optional. Summary of plans for the insurance being provided to the children. If a summary plan document is being provided as an additional attachment, follow the instructions below. Specifies whether an additional attachment is provided. Valid value: Y – Additional document provided. File naming format: ThirdPartyorPlanAdministratorFEIN.EmployerFEIN.EmployeeLastname.CCYYMMDDHHMM.sequenceNumber.pdf or Word (all versions). Comma-separated values must be provided. When an additional document is being provided, values in this field must be formatted as follows: Y, 123456789.999999999.JONE.202005191015.001.pdf. When an employer sends a file, the first node is not required–that is, ThirdPartyorPlanAdministratorFEIN. If a summary plan document is being provided as a downloadable file from the cloud, add the URL in this field.
Medical Insurance Provider Name	60	278–337	A/N	Optional. The name of the medical insurance provider that will cover the children.
Medical Insurance Group Number	11	338–348	A/N	Conditionally required; if the Medical Insurance Provider Name field is filled, this field must be filled. The group number of the medical insurance provider that will cover the children.
Medical Insurance Policy Number	20	349–368	A/N	Conditionally required; if the Medical Insurance Provider Name field is filled, this field must be filled. The policy number for the medical insurance of the children's healthcare coverage. If Policy Number is not available when sending this response, enter Not Yet Available.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Medical Insurance Address Line 1 Text	25	369–393	A/N	Conditionally required; if the Medical Insurance Provider Name field is filled, this field must be filled. The street address of the medical insurance provider.
Medical Insurance Address Line 2 Text	25	394–418	A/N	Optional. The street address of the medical insurance provider.
Medical Insurance Address Line 3 Text	25	419–443	A/N	Optional. The street address of the medical insurance provider.
Medical Insurance Address City Name	22	444–465	A/N	Conditionally required; if the Medical Insurance Provider Name field is filled, this field must be filled. The city of the medical insurance provider.
Medical Insurance Address State Code	2	466–467	A	Conditionally required; if the Medical Insurance Provider Name field is filled, this field must be filled. The state code of the medical insurance provider.
Medical Insurance Address ZIP Code	5	468–472	N	Conditionally required; if the Medical Insurance Provider Name field is filled, this field must be filled. The ZIP code of the medical insurance provider.
Medical Insurance Address ZIP Code Extension	4	473–476	N	Optional. The ZIP code extension of the medical insurance provider.
Dental Coverage Indicator	1	477–477	A	Optional; if the medical insurance also includes dental insurance coverage, this field must be filled. Valid value: Y – Dental coverage included. Fill with spaces if the medical insurance does not include dental insurance coverage.
Vision Coverage Indicator	1	478–478	A	Optional; if the medical insurance also includes vision insurance coverage, this field must be filled. Valid value: Y – Vision coverage included. Fill with spaces if the medical insurance does not include vision insurance coverage.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Prescription Drug Coverage Indicator	1	479–479	A	Optional; if the medical insurance also includes prescription drug insurance coverage, this field must be filled. Valid value: Y – Prescription drug coverage included. Fill with spaces if the medical insurance does not include prescription drug insurance coverage.
Mental Health Coverage Indicator	1	480–480	A	Optional; if the medical insurance also includes mental health insurance coverage, this field must be filled. Valid value: Y – Mental health coverage included. Fill with spaces if the medical insurance does not include mental health insurance coverage.
Other Health Coverage Indicator	1	481–481	A	Optional; if the medical insurance also includes other health insurance coverage, this field must be filled. Valid value: Y – Other health coverage included. Fill with spaces if the medical insurance does not include other health insurance coverage.
Other Coverage Type Description	60	482–541	A/N	Conditionally required; must be filled if the Other Health Coverage Indicator field is filled. A description of the type of coverage provided.
Dental Insurance Provider Name	60	542–601	A/N	Optional. The name of the dental insurance provider that will cover the children.
Dental Insurance Group Number	11	602–612	A/N	Conditionally required; if the Dental Insurance Provider Name field is filled, this field must be filled. The group number of the dental insurance provider that will cover the children.
Dental Insurance Policy Number	20	613–632	A/N	Conditionally required; if the Dental Insurance Provider Name field is filled, this field must be filled. The policy number for the dental insurance provider of the children's healthcare coverage. If Policy Number is not available when sending this response, enter Not Yet Available.
Dental Insurance Address Line 1 Text	25	633–657	A/N	Conditionally required; if the Dental Insurance Provider Name field is filled, this field must be filled. The street address of the dental insurance provider.
Dental Insurance Address Line 2 Text	25	658–682	A/N	Optional. The street address of the dental insurance provider.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Dental Insurance Address Line 3 Text	25	683–707	A/N	Optional. The street address of the dental insurance provider.
Dental Insurance Address City Name	22	708–729	A/N	Conditionally required; if the Dental Insurance Provider Name field is filled, this field must be filled. The city of the dental insurance provider.
Dental Insurance Address State Code	2	730–731	A	Conditionally required; if the Dental Insurance Provider Name field is filled, this field must be filled. The state code of the dental insurance provider.
Dental Insurance Address ZIP Code	5	732–736	N	Conditionally required; if the Dental Insurance Provider Name field is filled, this field must be filled. The ZIP code of the dental insurance provider.
Dental Insurance Address ZIP Code Extension	4	737–740	N	Optional. The ZIP code extension of the dental insurance provider.
Vision Insurance Provider Name	60	741–800	A/N	Optional. The name of the vision insurance provider that will cover the children.
Vision Insurance Group Number	11	801–811	A/N	Conditionally required; if the Vision Insurance Provider Name field is filled, this field must be filled. The group number of the vision insurance provider that will cover the children.
Vision Insurance Policy Number	20	812–831	A/N	Conditionally required; if the Vision Insurance Provider Name field is filled, this field must be filled. The policy number for the vision insurance of the children's healthcare coverage. If Policy Number is not available when sending this response, enter Not Yet Available.
Vision Insurance Address Line 1 Text	25	832–856	A/N	Conditionally required; if the Vision Insurance Provider Name field is filled, this field must be filled. The street address of the vision insurance provider.
Vision Insurance Address Line 2 Text	25	857–881	A/N	Optional. The street address of the vision insurance provider.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Vision Insurance Address Line 3 Text	25	882–906	A/N	Optional. The street address of the vision insurance provider.
Vision Insurance Address City Name	22	907–928	A/N	Conditionally required; if the Vision Insurance Provider Name field is filled, this field must be filled. The city of the vision insurance provider.
Vision Insurance Address State Code	2	929–930	A	Conditionally required; if the Vision Insurance Provider Name field is filled, this field must be filled. The state code of the vision insurance provider.
Vision Insurance Address ZIP Code	5	931–935	N	Conditionally required; if the Vision Insurance Provider Name field is filled, this field must be filled. The ZIP code of the vision insurance provider.
Vision Insurance Address ZIP Code Extension	4	936–939	N	Optional. The ZIP code extension of the vision insurance provider.
Prescription Drug Insurance Provider Name	60	940–999	A/N	Optional. The name of the prescription drug insurance provider that will cover the children.
Prescription Drug Insurance Group Number	11	1000–1010	A/N	Conditionally required; if the Prescription Drug Insurance Provider Name field is filled, this field must be filled. The group number of the prescription drug insurance provider that will cover the children.
Prescription Drug Insurance Policy Number	20	1011–1030	A/N	Conditionally required; if the Prescription Drug Insurance Provider Name field is filled, this field must be filled. The policy number for the prescription drug insurance of the children's healthcare coverage. If Policy Number is not available when sending this response, enter Not Yet Available.
Prescription Drug Insurance Address Line 1 Text	25	1031–1055	A/N	Conditionally required; if the Prescription Drug Insurance Provider Name field is filled, this field must be filled. The street address of the prescription drug insurance provider.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Prescription Drug Insurance Address Line 2 Text	25	1056–1080	A/N	Optional. The street address of the prescription drug insurance provider.
Prescription Drug Insurance Address Line 3 Text	25	1081–1105	A/N	Optional. The street address of the prescription drug insurance provider.
Prescription Drug Insurance Address City Name	22	1106–1127	A/N	Conditionally required; if the Prescription Drug Insurance Provider Name field is filled, this field must be filled. The city of the prescription drug insurance provider.
Prescription Drug Insurance Address State Code	2	1128–1129	A	Conditionally required; if the Prescription Drug Insurance Provider Name field is filled, this field must be filled. The state code of the prescription drug insurance provider.
Prescription Drug Insurance Address ZIP Code	5	1130–1134	N	Conditionally required; if the Prescription Drug Insurance Provider Name field is filled, this field must be filled. The ZIP code of the prescription drug insurance provider.
Prescription Drug Insurance Address ZIP Code Extension	4	1135–1138	N	Optional. The ZIP code extension of the prescription drug insurance provider.
Mental Health Insurance Provider Name	60	1139–1198	A/N	Optional. The name of the mental health insurance provider that will cover the children.
Mental Health Insurance Group Number	11	1199–1209	A/N	Conditionally required; if the Mental Health Insurance Provider Name field is filled, this field must be filled. The group number of the mental health insurance provider that will cover the children.
Mental Health Insurance Policy Number	20	1210–1229	A/N	Conditionally required; if the Mental Health Insurance Provider Name field is filled, this field must be filled. The policy number for the mental health insurance of the children's healthcare coverage. If Policy Number is not available when sending this response, enter Not Yet Available.

Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Mental Health Insurance Address Line 1 Text	25	1230–1254	A/N	Conditionally required; if the Mental Health Insurance Provider Name field is filled, this field must be filled. The street address of the mental health insurance provider.
Mental Health Insurance Address Line 2 Text	25	1255–1279	A/N	Optional. The street address of the mental health insurance provider.
Mental Health Insurance Address Line 3 Text	25	1280–1304	A/N	Optional. The street address of the mental health insurance provider.
Mental Health Insurance Address City Name	22	1305–1326	A/N	Conditionally required; if the Mental Health Insurance Provider Name field is filled, this field must be filled. The city of the mental health insurance provider.
Mental Health Insurance Address State Code	2	1327–1328	A	Conditionally required; if the Mental Health Insurance Provider Name field is filled, this field must be filled. The state code of the mental health insurance provider.
Mental Health Insurance Address ZIP Code	5	1329–1333	N	Conditionally required; if the Mental Health Insurance Provider Name field is filled, this field must be filled. The ZIP code of the mental health insurance provider.
Mental Health Insurance Address ZIP Code Extension	4	1334–1337	N	Optional. The ZIP code extension of the mental health insurance provider.
Other Insurance Provider Name	60	1338–1397	A/N	Optional. The name of the state-requested other insurance provider that will cover the children.
Other Insurance Group Number	11	1398–1408	A/N	Conditionally required; if the Other Insurance Provider Name field is filled, this field must be filled. The group number of the other type of insurance, requested by the state, that will cover the children.
Other Insurance Policy Number	20	1409–1428	A/N	Conditionally required; if the Other Insurance Name field is filled, this field must be filled. The policy number of the other type of insurance, requested by the state, that will cover the children. If Policy Number is not available when sending this response, enter Not Yet Available.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Other Insurance Address Line 1 Text	25	1429–1453	A/N	Conditionally required; if the Other Insurance Name field is filled, this field must be filled. The street address of the other insurance provider.
Other Insurance Address Line 2 Text	25	1454–1478	A/N	Optional. The street address of the other insurance provider.
Other Insurance Address Line 3 Text	25	1479–1503	A/N	Optional. The street address of the other insurance provider.
Other Insurance Address City Name	22	1504–1525	A/N	Conditionally required; if the Other Insurance Name field is filled, this field must be filled. The city of the other insurance provider.
Other Insurance Address State Code	2	1526–1527	A	Conditionally required; if the Other Insurance Name field is filled, this field must be filled. The state code of the other insurance provider.
Other Insurance Address ZIP Code	5	1528–1532	N	Conditionally required; if the Other Insurance Name field is filled, this field must be filled. The ZIP code of the other insurance provider.
Other Insurance Address ZIP Code Extension	4	1533–1536	N	Optional. The ZIP code extension of the other insurance provider.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Multiple Plan Options Description Text	160	1537–1696	A/N	Conditionally required; must be filled if the Coverage Response Code field is 03. Notify the issuing agency of multiple plan options and any description, text, or URL the employer, third-party provider, or plan administrator wants to share with state agencies. If a multiple plan options document is being provided as an additional attachment, follow the instructions below. Specifies whether an additional attachment is provided. Valid value: Y – Additional document provided. File naming format: ThirdPartyorPlanAdministratorFEIN.EmployerFEIN.EmployeeLastname.CCYYMMDDHHMM.sequenceNumber.pdf or Word (all versions). Comma separated values must be provided. When an additional document is provided, values in this field must follow this example: Y, 123456789.999999999.JONE.202005191015.001.pdf. When the employer has a single PDF or Word document for plan options for multiple e-NMSN responses, the employer can use a name of its choice and a prefix with the employer's FEIN and include that name in all Part-B responses: Values in this field must follow this example: Y, ThirdPartyorPlanAdministratorFEIN.EmployerFEIN.Employer_Chosen_Name.CCYYMMDDHHMM.pdf. When an employer sends a file, the first node is not required – that is, ThirdPartyorPlanAdministratorFEIN.
Waiting Period Expiration Date	8	1697–1704	N	Conditionally required; if the employer uses 04 for the Coverage Response Code field, either the Waiting Period Expiration Date field or the Waiting Period Description Text field is required. The date when the waiting period ends, which is more than 90 days from the date of receipt of the notice. Must be in CCYYMMDD format.
Waiting Period Description Text	100	1705–1804	A/N	Optional. The terms of a waiting period that is determined by some measure other than the passage of time. If the employer uses 04 for the Coverage Response Code field, either the Waiting Period Expiration Date field or the Waiting Period Description Text field is required.

Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Not Qualified Medical Child Support Order Indicator	2	1805–1806	N	Conditionally required; either the Qualified Medical Child Support Order Determination Code field or the Not Qualified Medical Child Support Order Indicator field is required. Indicates the order is not a qualified medical child support order. Valid value: 05 – This notice does not constitute a qualified medical child support order. Fill with spaces if N/A.
Not Qualified Medical Child Support Order Indicator Reasons	2	1807–1808	N	Conditionally required; must be filled if the Not Qualified Medical Child Support Order Indicator field is 05. This notice does not constitute a qualified medical child support order. Valid values: 01 –The name of the children or participant is unavailable. 02 – The mailing address of the children (or a substituted official) or participant is unavailable. 03 – Children are above the age at which dependents are no longer eligible for coverage under the plan.
Ineligible Child 1 Last Name	20	1809–1828	A/N	Conditionally required; must be filled if the Not Qualified Medical Child Support Order Indicator field is 05. The last name of child 1 who is not eligible for healthcare coverage. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments

Ineligible Child 1 First Name	15	1829–1843	A/N	Conditionally required; must be filled if the Ineligible Child 1 Last Name field is filled.
				The first name of ineligible child 1.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				    Spaces
				The first character cannot be a space.

Ineligible Child 1 Middle Name or Initial	15	1844–1858	A/N	Optional.
				The middle name or initial of ineligible child 1.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				The first character cannot be a space if the middle name is populated.
				Fill with spaces if no middle name is available.

Ineligible Child 1 Suffix Text	4	1859–1862	A/N	Optional.
				The name suffix of ineligible child 1 – for example Jr., Sr., or III.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				The first character cannot be a space.
				Fill with spaces if no name suffix is available.

Ineligible Child 1 Gender	1	1863–1863	A	Conditionally required; must be filled if the Ineligible Child 1 Last Name field is filled.
				The gender of ineligible child 1.
				Valid values:
				    F – Female
				    M – Male
				    U – Unknown

Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Ineligible Child 1 Date of Birth	8	1864–1871	N	Conditionally required; must be filled if the Ineligible Child 1 Last Name field is filled. Ineligible child 1's DOB in CCYYMMDD format.
Ineligible Child 1 Social Security Number	9	1872–1880	N	Conditionally required; must be filled if the Ineligible Child 1 Last Name field is filled. The SSN of ineligible child 1.

Ineligible Child 2 Last Name	20	1881–1900	A/N	Optional.
				The last name of child 2 who is not eligible for healthcare coverage.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				    Spaces
				The first character cannot be a space.

Ineligible Child 2 First Name	15	1901–1915	A/N	Conditionally required; must be filled if the Ineligible Child 2 Last Name field is filled.
				The first name of ineligible child 2.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				    Spaces
				The first character cannot be a space.

Ineligible Child 2 Middle Name or Initial	15	1916–1930	A/N	Optional.
				The middle name or initial of ineligible child 2.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				The first character cannot be a space if the middle name is populated.
				Fill with spaces if no middle name is available.

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Field Name	Length	Location	A/N	Comments

Ineligible Child 2 Suffix Text	4	1931–1934	A/N	Optional.
				The name suffix of ineligible child 2 – for example, Jr., Sr., or III.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				The first character cannot be a space.
				Fill with spaces if no name suffix is available.

Ineligible Child 2 Gender	1	1935–1935	A	Conditionally required; must be filled if the Ineligible Child 2 Last Name field is filled.
				The gender of ineligible child 2.
				Valid values:
				    F – Female
				    M – Male
				    U – Unknown

Ineligible Child 2 Date of Birth	8	1936–1943	N	Conditionally required; must be filled if the Ineligible Child 2 Last Name field is filled. Ineligible child 2's DOB in CCYYMMDD format.
Ineligible Child 2 Social Security Number	9	1944–1952	N	Conditionally required; must be filled if the Ineligible Child 2 Last Name field is filled. The SSN of ineligible child 2.

Ineligible Child 3 Last Name	20	1953–1972	A/N	Optional.
				The last name of child 3 who is not eligible for healthcare coverage.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				    Spaces
				The first character cannot be a space.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Ineligible Child 3 First Name	15	1973–1987	A/N	Conditionally required; must be filled if the Ineligible Child 3 Last Name field is filled. The first name of ineligible child 3. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.
Ineligible Child 3 Middle Name or Initial	15	1988–2002	A/N	Optional. The middle name or initial of ineligible child 3. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) The first character cannot be a space if the middle name is populated. Fill with spaces if no middle name is available.
Ineligible Child 3 Suffix Text	4	2003–2006	A/N	Optional. The name suffix of ineligible child 3 – for example, Jr., Sr., or III. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) The first character cannot be a space. Fill with spaces if no name suffix is available.
Ineligible Child 3 Gender	1	2007–2007	A	Conditionally required; must be filled if the Ineligible Child 3 Last Name field is filled. The gender of ineligible child 3. Valid values: F – Female M – Male U – Unknown

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Ineligible Child 3 Date of Birth	8	2008–2015	N	Conditionally required; must be filled if the Ineligible Child 3 Last Name field is filled. Ineligible child 3's DOB in CCYYMMDD format.
Ineligible Child 3 Social Security Number	9	2016–2024	N	Conditionally required; must be filled if the Ineligible Child 3 Last Name field is filled. The SSN of ineligible child 3.
Ineligible Child 4 Last Name	20	2025–2044	A/N	Optional. The last name of child 4 who is not eligible for healthcare coverage. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.
Ineligible Child 4 First Name	15	2045–2059	A/N	Conditionally required; must be filled if the Ineligible Child 4 Last Name field is filled. The first name of ineligible child 4. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.
Ineligible Child 4 Middle Name or Initial	15	2060–2074	A/N	Optional. The middle name or initial of ineligible child 4. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) The first character cannot be a space if the middle name is populated. Fill with spaces if no middle name is available.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Ineligible Child 4 Suffix Text	4	2075–2078	A/N	Optional. The name suffix of ineligible child 4 – for example, Jr., Sr., or III. Valid special characters: 　Hyphens (-) 　Apostrophes (') 　Periods (.) The first character cannot be a space. Fill with spaces if no name suffix is available.
Ineligible Child 4 Gender	1	2079–2079	A	Conditionally required; must be filled if the Ineligible Child 4 Last Name field is filled. The gender of ineligible child 4. Valid values: 　F – Female 　M – Male 　U – Unknown
Ineligible Child 4 Date of Birth	8	2080–2087	N	Conditionally required; must be filled if the Ineligible Child 4 Last Name field is filled. Ineligible child 4's DOB in CCYYMMDD format.
Ineligible Child 4 Social Security Number	9	2088–2096	N	Conditionally required; must be filled if the Ineligible Child 4 Last Name field is filled. The SSN of ineligible child 4.
Ineligible Child 5 Last Name	20	2097–2116	A/N	Optional. The last name of child 5 who is not eligible for healthcare coverage. Valid special characters: 　Hyphens (-) 　Apostrophes (') 　Periods (.) 　Spaces The first character cannot be a space.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Ineligible Child 5 First Name	15	2117–2131	A/N	Conditionally required; must be filled if the Ineligible Child 5 Last Name field is filled. The first name of ineligible child 5. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.
Ineligible Child 5 Middle Name or Initial	15	2132–2146	A/N	Optional. The middle name or initial of ineligible child 5. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) The first character cannot be a space if the middle name is populated. Fill with spaces if no middle name is available.
Ineligible Child 5 Suffix Text	4	2147–2150	A/N	Optional. The name suffix of ineligible child 5 – for example, Jr., Sr., or III. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) The first character cannot be a space. Fill with spaces if no name suffix is available.
Ineligible Child 5 Gender	1	2151–2151	A	Conditionally required; must be filled if the Ineligible Child 5 Last Name field is filled. The gender of ineligible child 5. Valid values: F – Female M – Male U – Unknown

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Ineligible Child 5 Date of Birth	8	2152–2159	N	Conditionally required; must be filled if the Ineligible Child 5 Last Name field is filled. Ineligible child 5's DOB in CCYYMMDD format.
Ineligible Child 5 Social Security Number	9	2160–2168	N	Conditionally required; must be filled if the Ineligible Child 5 Last Name field is filled. The SSN of ineligible child 5.
Ineligible Child 6 Last Name	20	2169–2188	A/N	Optional. The last name of child 6 who is not eligible for healthcare coverage. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.
Ineligible Child 6 First Name	15	2189–2203	A/N	Conditionally required; must be filled if the Ineligible Child 6 Last Name field is filled. The first name of ineligible child 6. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.
Ineligible Child 6 Middle Name or Initial	15	2204–2218	A/N	Optional. The middle name or initial of ineligible child 6. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) The first character cannot be a space if the middle name is populated. Fill with spaces if no middle name is available.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments

Ineligible Child 6 Suffix Text	4	2219–2222	A/N	Optional.
				The name suffix for ineligible child 6 – for example, Jr., Sr., or III.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				The first character cannot be a space.
				Fill with spaces if no name suffix is available.

Ineligible Child 6 Gender	1	2223–2223	A	Conditionally required; must be filled if the Ineligible Child 6 Last Name field is filled.
				The gender of ineligible child 6.
				Valid values:
				    F – Female
				    M – Male
				    U – Unknown

Ineligible Child 6 Date of Birth	8	2224–2231	N	Conditionally required; must be filled if the Ineligible Child 6 Last Name field is filled. Ineligible child 6's DOB in CCYYMMDD format.
Ineligible Child 6 Social Security Number	9	2232–2240	N	Conditionally required; must be filled if the Ineligible Child 6 Last Name field is filled. The SSN of ineligible child 6.

Ineligible Child 7 Last Name	20	2241–2260	A/N	Optional.
				The last name of child 7 who is not eligible for healthcare coverage.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				    Spaces
				The first character cannot be a space.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Ineligible Child 7 First Name	15	2261–2275	A/N	Conditionally required; must be filled if the Ineligible Child 7 Last Name field is filled. The first name of ineligible child 7. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.
Ineligible Child 7 Middle Name or Initial	15	2276–2290	A/N	Optional. The middle name or initial of ineligible child 7. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) The first character cannot be a space if the middle name is populated. Fill with spaces if no middle name is available.
Ineligible Child 7 Suffix Text	4	2291–2294	A/N	Optional. The name suffix for ineligible child 7 – for example, Jr., Sr., or III. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) The first character cannot be a space. Fill with spaces if no name suffix is available.
Ineligible Child 7 Gender	1	2295–2295	A	Conditionally required; must be filled if the Ineligible Child 7 Last Name field is filled. The gender of ineligible child 7. Valid values: F – Female M – Male U – Unknown

Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Ineligible Child 7 Date of Birth	8	2296–2303	N	Conditionally required; must be filled if the Ineligible Child 7 Last Name field is filled. Ineligible child 7's DOB in CCYYMMDD format.
Ineligible Child 7 Social Security Number	9	2304–2312	N	Conditionally required; must be filled if the Ineligible Child 7 Last Name field is filled. The SSN of ineligible child 7.
Ineligible Child 8 Last Name	20	2313–2332	A/N	Optional. The last name of child 8 who is not eligible for healthcare coverage. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.
Ineligible Child 8 First Name	15	2333–2347	A/N	Conditionally required; must be filled if the Ineligible Child 8 Last Name field is filled. The first name of ineligible child 6. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.
Ineligible Child 8 Middle Name or Initial	15	2348–2362	A/N	Optional. The middle name or initial of ineligible child 8. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) The first character cannot be a space if the middle name is populated. Fill with spaces if no middle name is available.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Ineligible Child 8 Suffix Text	4	2363–2366	A/N	Optional. The name suffix for ineligible child 8 – for example, Jr., Sr., or III. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) The first character cannot be a space. Fill with spaces if no name suffix is available.
Ineligible Child 8 Gender	1	2367–2367	A	Conditionally required; must be filled if the Ineligible Child 8 Last Name field is filled. The gender of ineligible child 8. Valid values: F – Female M – Male U – Unknown
Ineligible Child 8 Date of Birth	8	2368–2375	N	Conditionally required; must be filled if the Ineligible Child 8 Last Name field is filled. Ineligible child 8's DOB in CCYYMMDD format.
Ineligible Child 8 Social Security Number	9	2376–2384	N	Conditionally required; must be filled if the Ineligible Child 8 Last Name field is filled. The SSN of ineligible child 8.
Plan Administrator or Representative Last Name	20	2385–2404	A/N	Required. The last name of the plan administrator to contact if the state has additional questions. Valid special characters: Hyphens (-) Apostrophes (') Periods (.) Spaces The first character cannot be a space.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments

Plan Administrator or Representative First Name	15	2405–2419	A/N	Required.
				The first name of the plan administrator to contact if the state has additional questions.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				    Spaces
				The first character cannot be a space.

Plan Administrator or Representative Middle Name or Initial	15	2420–2434	A/N	Optional.
				The plan administrator's middle name or initial.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				The first character cannot be a space if the middle name is populated.
				Fill with spaces if no middle name is available.

Plan Administrator or Representative Suffix Name	4	2435–2438	A/N	Optional.
				The plan administrator's name suffix – for example, Jr., Sr., or III.
				Valid special characters:
				    Hyphens (-)
				    Apostrophes (')
				    Periods (.)
				The first character cannot be a space.
				Fill with spaces if no name suffix is available.

Plan Administrator or Representative Telephone Number	10	2439–2448	N	Required. The plan administrator's phone number.
Plan Administrator or Representative Title Text	60	2449–2508	A/N	Required. The business title of the plan administrator, representative, or customer service contact.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Plan Administrator Response Completion Date	8	2509–2516	N	Required. The date when the plan administrator or employer representative completed the Plan Administrator Response. Must be in CCYYMMDD format.
Plan Administrator or Representative Address Line 1 Text	25	2517–2541	A/N	Required. The street address of the plan administrator or representative.
Plan Administrator or Representative Address Line 2 Text	25	2542–2566	A/N	Optional. The street address of the plan administrator or representative.
Plan Administrator or Representative Address Line 3 Text	25	2567–2591	A/N	Optional. The street address of the plan administrator or representative.
Plan Administrator or Representative Address City Name	22	2592–2613	A/N	Required. The city of the plan administrator or representative.
Plan Administrator or Representative Address State Code	2	2614–2615	A	Required. The state code of the plan administrator or representative.
Plan Administrator or Representative Address ZIP Code	5	2616–2620	N	Required. The ZIP code of the plan administrator or representative.
Plan Administrator or Representative Address ZIP Code Extension	4	2621–2624	N	Optional. The ZIP code extension of the plan administrator or representative.

Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Plan Administrator or Representative Email Address	65	2625-2689	A/N	Optional. The plan administrator or representative email. Valid special characters: Hyphens (-) Underscore (_) Periods (.) At sign(@) The first character cannot be a space.
Medical Effective Date of Coverage	8	2690-2697	N	Conditionally required; if the Medical Insurance Name field is filled, this field must be filled. The effective date of medical coverage. Must be in CCYYMMDD format.
Medical Phone Number for Claims	10	2698-2707	N	Conditionally required; if the Medical Insurance Name field is filled, this field must be filled. Telephone number for medical claims.
Dental Effective Date of Coverage	8	2708-2715	N	Conditionally required; if the Dental Insurance Name field is filled, this field must be filled. The effective date of dental coverage. Must be in CCYYMMDD format.
Dental Phone Number for Claims	10	2716-2725	N	Conditionally required; if the Dental Insurance Name field is filled, this field must be filled. Telephone number for dental claims.
Vision Effective Date of Coverage	8	2726-2733	N	Conditionally required; if the Vision Insurance Name field is filled, this field must be filled. The effective date of vision coverage. Must be in CCYYMMDD format.
Vision Phone Number for Claims	10	2734-2743	N	Conditionally required; if the Vision Insurance Name field is filled, this field must be filled. Telephone number for vision claims.
Prescription Effective Date of Coverage	8	2744-2751	N	Conditionally required; if the Prescription Insurance Name field is filled, this field must be filled. The effective date of prescription coverage. Must be in CCYYMMDD format.

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Chart E-2: Electronic Part-B Response Detail Record Layout				
Field Name	Length	Location	A/N	Comments
Prescription Phone Number for Claims	10	27522761	N	Conditionally required; if the Prescription Insurance Name field is filled, this field must be filled. Telephone number for prescription claims.
Mental Insurance Effective Date of Coverage	8	2762-2769	N	Conditionally required; if the Mental Insurance Name field is filled, this field must be filled. The effective date of mental insurance coverage. Must be in CCYYMMDD format.
Mental Phone Number for Claims	10	2770-2779	N	Conditionally required; if the Mental Insurance Name field is filled, this field must be filled. Telephone number for mental claims.
Other Insurance Effective Date of Coverage	8	2780-2787	N	Conditionally required; if the Other Insurance Name field is filled, this field must be filled. The effective date of other insurance coverage. Must be in CCYYMMDD format.
Other Phone Number for Claims	10	2788-2797	N	Conditionally required; if the Other Insurance Name field is filled, this field must be filled. Telephone number for other insurance claims.
Employee SSN	9	2798-2806	N	Required. The employee's SSN.
Filler	100	2807-2906	A/N	This is for future versions. For this version, fill with spaces.

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Error: Reference source not found contains the Electronic Part-B Response Trailer Record layout.

Chart E-3: Electronic Part-B Response Trailer Record Layout				
Field Name	Length	Location	A/N	Comments
Record Identifier	4	1–4	A	Required. The letters BRFT, which identify the record as a Part-B Response trailer.
Employer FEIN	9	5–13	N	Required. The employer's FEIN.
Third-party FEIN	9	14–22	N	Conditionally required; must be filled if the third-party provider is responding to Part-A and Part-B. The FEIN of the third-party provider responding to both Part-A and Part-B.
Plan Administrator FEIN	9	23–31	N	Conditionally required. The FEIN of the third-party plan administrator processing only a Part-B response for an employer.
FIPS Code	2	32–33	N	Required. The two-digit numeric locator code of the requesting state.

Record Count	6	34–39	N	Required.
				The total number of records submitted in this batch.
				The field must be formatted as follows:
				  Numeric
				  Unsigned
				  Right-justified
				  Zero fill to left
				  Zero fill if N/A

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Chart E-3: Electronic Part-B Response Trailer Record Layout				
Field Name	Length	Location	A/N	Comments

Portal Error Message Text	29	40–68	A/N	For Portal use.
				Generated when the Portal performed its validation and found errors. Trailer records with errors return the entire batch. The returned batch contains all the requests originally sent. Filled with spaces by the requestor.
				Valid value:
				    BTCR – Invalid data in a conditionally-required field
				    BTRF – Required field validation error
				Each code is separated by a comma.
				Left-justified and padded with spaces to the right.

Filler	2838	69–2906	A/N	This is for future versions. For this version, fill with spaces.