

## HHS Compliance Review Program Triage Questionnaire Health Plans

## Section 1. Organization and Point of Contact Information

Organization Information						
Organization				Doing		
Name:				Business As:		
Is your organization currently going through liquidation? $\Box$ Yes $\Box$ No						
If yes, please descri	be the phase.					
Contact Name:				Title:		
Telephone:				E-mail:		
Business Address:				City:		
State/Province:			Country:		Zip:	

Point of Contact Information					
🗆 Check if same	as above				
Organization					
Name:					
Contact Name:			Title:		
Telephone:			E-mail:		
Business			City:		
Address:					
State/Province:		Country:		Zip:	

## Section 2. Type of Covered Entity

Check All That Apply	
$\Box$ Large Health Plan <sup>1</sup>	Business Associate
□ Small Health Plan <sup>2</sup>	

<sup>1</sup> Annual receipts > 5 million

<sup>2</sup> Annual receipts < \$5 million (per regulation 45 CFR 160.103)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1390 from the year of 2024 through 2025. The objective of the HIPAA Administrative Simplification information collection program is to conduct assessments and identify whether a covered entity is compliant with the HIPAA - adopted standards, and administrative simplification. The time required to complete this information collection is estimated to average less than **10 hours** per response (4 forms x 60 minutes/form), including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory (under 45 CFR § 160.310) If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



## Health Plans - Required HIPAA Covered Transactions:

For each transaction listed below, select the appropriate check box, and provide additional details as requested. A response is expected for each transaction type.

Eligibility Inquiry for a Health Plan			
5010, 271 Health Care Eligibility Benefit Information Response			
Does your organization construct and/or transmit this transaction electronically to a trading partner?	□ Yes □ No □ N/A		
If <b>YES:</b> By what means?	🗆 Real Time 🗆 Batch		
If <b>NO</b> : Has your organization ever been asked to provide this transaction electronically?			
In the space below, please provide an explanation as to why your	□ Yes □ No		
organization does not construct and/or transmit this transaction			
to a trading partner.			
If N/A: In the space below, please provide an explanation as to why			
required to construct and or transmit this transaction to a trading pa	artner.		
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	🗆 Yes 🗆 No		
If <b>Yes:</b> Please provide the company or entity name:			



Uselth Come Claim Chatan			
Health Care Claim Status			
5010, 277 Health Care Claim Status Response			
Does your organization construct and/or transmit this transaction	□ Yes □ No □ N/A		
electronically to a trading partner?			
If <b>YES:</b> By what means?	🗆 Real Time 🗆 Batch		
If NO: Has your organization ever been asked to provide this			
transaction electronically?			
	🗆 Yes 🗆 No		
In the space below, please provide an explanation as to why your			
organization does not construct and/or transmit this transaction			
to a trading partner.			
If NI/A. In the analytic places provide an evaluation as to why	vous orconization is not		
If N/A: In the space below, please provide an explanation as to why			
required to construct and or transmit this transaction to a trading particular terms of the transmit the transaction to a trading particular terms of the terms of te	artner.		
Does another company or entity construct and/or transmit this	🗆 Yes 🗆 No		
transaction on behalf of your organization?			
If <b>Yes:</b> Please provide the company or entity name:			



Referral Certification and Authorization			
5010, 278 Health Care Services Review Response			
Does your organization construct and/or transmit this transaction	□ Yes □ No □ N/A		
electronically to a trading partner? If <b>YES:</b> By what means?	□ Real Time □ Batch		
If <b>NO</b> : Has your organization ever been asked to provide this			
transaction electronically?			
	🗆 Yes 🗆 No		
In the space below, please provide an explanation as to why your			
organization does not construct and/or transmit this transaction			
to a trading partner.			
If N/A: In the space below, please provide an explanation as to wh	y your organization is not		
required to construct and or transmit this transaction to a trading	partner.		
Does another company or entity construct and/or transmit this			
transaction on behalf of your organization?	□ Yes □ No		
If <b>Yes:</b> Please provide the company or entity name:			



Health Care Remittance Advice			
5010, 835 Health Care Claim Payment/Advice			
Does your organization construct and/or transmit this transaction electronically to a trading partner?	□ Yes □ No □ N/A		
If <b>NO</b> : Has your organization ever been asked to provide this transaction electronically?			
In the space below, please provide an explanation as to why your organization does not construct and/or transmit this transaction to a trading partner.	🗆 Yes 🗆 No		
If N/A: In the space below, please provide an explanation as to why your organization is not required to construct and or transmit this transaction to a trading partner.			
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	🗆 Yes 🗆 No		
If <b>Yes:</b> Please provide the company or entity name:			



Coordination of Benefit (COB) Claim or Encounter 5010, 837 Health Care Claim - Institutional			
Does your organization receive, process, and forward claims electronically to any trading partner (secondary or tertiary payers) for subsequent payment (COB)? Or Does your organization transfer encounter information electronically?	□ Yes □ No □ N/A		
If NO: Has your organization ever been asked to provide this transaction electronically? In the space below, please provide an explanation as to why your organization does not construct and/or transmit this transaction to a trading partner.	□ Yes □ No		
If N/A: In the space below, please provide an explanation as to why	your organization is not		
required to construct and or transmit this transaction to a trading pa	artner.		
Does another company or entity construct and/or transmit this transaction on behalf of your organization? If <b>Yes:</b> Please provide the company or entity name:	□ Yes □ No		



Coordination of Benefit (COB) Claim or Encounter			
5010, 837 Health Care Claim - Professional			
Does your organization receive, process, and forward claims electronically to any trading partner (secondary or tertiary payer for subsequent payment (COB)?	rs)		
Or	□ Yes □ No □ N/A		
Does your organization transfer encounter information electronically?			
If <b>NO</b> : Has your organization ever been asked to provide this transaction electronically?			
In the space below, please provide an explanation as to why you organization does not construct and/or transmit this transaction to a trading partner.			
If N/A: In the space below, please provide an explanation as to v required to construct and or transmit this transaction to a tradin			
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	🗆 Yes 🗆 No		
If <b>Yes:</b> Please provide the company or entity name:			



Consultantian of Domofit (COD) Claims on Engagements			
Coordination of Benefit (COB) Claim or Encounter			
5010, 837 Health Care Claim - Dental			
Does your organization receive, process, and forward claims			
electronically to any trading partner (secondary or tertiary payers)			
for subsequent payment (COB)?	□ Yes □ No □ N/A		
Or			
Does your organization transfer encounter information			
electronically?			
If <b>NO</b> : Has your organization ever been asked to provide this			
transaction electronically?			
	🗆 Yes 🗆 No		
In the space below, please provide an explanation as to why your			
organization does not construct and/or transmit this transaction			
to a trading partner.			
If N/A: In the space below, please provide an explanation as to why	your organization is not		
required to construct and or transmit this transaction to a trading pa	artner.		
Does another company or entity construct and/or transmit this			
transaction on behalf of your organization?	🗆 Yes 🗆 No		
If <b>Yes:</b> Please provide the company or entity name:	·		



Coordination of Benefit (COB) Claim or Encounter NCPDP D.0 Pharmacy Claim			
Does your organization receive, process, and forward claims electronically to any trading partner (secondary or tertiary payers) for subsequent payment (COB)? Or Does your organization transfer encounter information electronically?	□ Yes □ No □ N/A		
If <b>NO</b> : Has your organization ever been asked to provide this transaction electronically? In the space below, please provide an explanation as to why your organization does not construct and/or transmit this transaction to a trading partner.	□ Yes □ No		
If N/A: In the space below, please provide an explanation as to why your organization is not required to construct and or transmit this transaction to a trading partner.			
Does another company or entity construct and/or transmit this transaction on behalf of your organization? If <b>Yes:</b> Please provide the company or entity name:	□ Yes □ No		



Health Plan Premium Payment			
5010, 820 Premium Payment			
Does your organization construct and/or transmit this transaction electronically to a trading partner?	□ Yes □ No □ N/A		
If <b>NO</b> : Has your organization ever been asked to provide this transaction electronically?			
In the space below, please provide an explanation as to why your organization does not construct and/or transmit this transaction to a trading partner.	□ Yes □ No		
If N/A: In the space below, please provide an explanation as to why your organization is not required to construct and or transmit this transaction to a trading partner.			
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	🗆 Yes 🗆 No		
If <b>Yes:</b> Please provide the company or entity name:			



Enrollment and Disenrollment in a Health Plan 5010, 834 Health Care Benefits Enrollment and Maintenance	
Does your organization construct and/or transmit this transaction electronically to a trading partner?	□ Yes □ No □ N/A
If <b>NO</b> : Has your organization ever been asked to provide this transaction electronically?	
In the space below, please provide an explanation as to why your organization does not construct and/or transmit this transaction to a trading partner.	🗆 Yes 🗆 No
If N/A: In the space below, please provide an explanation as to why your organization is not required to construct and or transmit this transaction to a trading partner.	
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	🗆 Yes 🗆 No
If <b>Yes:</b> Please provide the company or entity name:	