

**Indian Health Service
HIPAA Readiness Survey
Third-Party Payers**

Healthcare plans, healthcare clearinghouses, and healthcare providers who utilize electronic transactions will be required to use these standards beginning October 16, 2002 unless they apply for a waiver or extension.

Indian Health Service is preparing to meet the October 16, 2003 deadline to have its electronic systems prepared to submit HIPAA compliant transaction codes.

Indian Health Service has identified your company as one that we have sent electronic transactions to in the past. To provide us with guidance on your company's readiness, please fill out the following questionnaire and return the completed document to our office.

Please complete the attached questionnaire and return it by fax or email attachment to the attention of:

**Gail Townsend
Information Technology Support Center
Indian Health Service
Phone: 505-248-4125. Fax 505-248-4199
Email: gail.townsend2@mail.ihs.gov**

**Indian Health Service
HIPAA Readiness Survey
Third-Party Payers**

Date: _____

Name of Insurance Company: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Name of Person Completing Questionnaire: _____

Phone #/Fax: _____

Please complete the following:

Will your company be prepared to implement the following by 10/16/2003?

HIPAA format	Yes	No	Waiver until 10/2003	N/A	DATE ready for testing?	Contact Person/phone number/email address
270 Health Insurance Eligibility Request Verification for covered services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
271 Health Insurance Response verification for covered services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
835 Health Care Claim Payment/Remittance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
837 Health Care Claim – <i>Institutional</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
837 Health Care Claim or Encounter – <i>Dental</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
837 – Health Care Claim or Encounter – <i>Professional</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
276 Health Care Claim Inquiry to request status of claim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
277 Health Care Claim response to report the status of a claim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Comments: _____