



# **Health Net Small Group Census Enrollment Guide**

**California Groups**

*As of: January 2019*

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## INTRODUCTION

The use of the Census Enrollment Excel spreadsheet provides a tool to give Health Net enrollment information for new groups. Health Net's Membership Eligibility database is interfaced directly from the incoming data file. This eliminates the need for employers to submit paper forms to Health Net's Membership Eligibility and Accounting Department for new group enrollments.

## PARTICIPATION

All small group employers may submit their membership data through the completion of the Census Enrollment spreadsheet.

***By use of enrolling via Census Enrollment, the Employer agrees that all data has been validated as this process does not verify or validate the applicant data.***

## OBJECTIVES AND BENEFITS

The objective of the Census Enrollment spreadsheet is to streamline the enrollment process.

The Census Enrollment spreadsheet is a process by which the eligibility data is provided electronically in fixed fields to Health Net and then loaded directly into our system. This has the following advantages:

- Eliminates excess paperwork.
- Eligibility can be loaded directly into our system with minimal (if any) manual interference.
- Processing time is shorter; therefore, ID Cards are generated quicker.
- Manual entry errors are eliminated.

## RECORD RETENTION

Since the eligibility forms are not being physically forwarded to Health Net for retention, the trading partner agrees to maintain the signed Enrollment Form for verification purposes. The signed enrollment documents to be retained must be Health Net's Enrollment Form. In addition, the Enrollment Form must be executed prior to the delivery of the Census Enrollment file of that member(s)' data to Health Net, and includes the Acceptance of Coverage section. The trading partner also agrees to supply Health Net with a copy of the signed enrollment form upon request. **If the arbitration agreement clause on the enrollment form is not signed or is modified in any way, the enrollment data must not be sent to Health Net for those members.**

## AUDIT RIGHTS

Health Net reserves the right to conduct periodic audits on the data received against the Enrollment Forms retained by the Employer and/or Broker.

## DATA TRANSMISSION

The Census Enrollment spreadsheet must be sent to Health Net Underwriting or Sales Department via encrypted email.

## HEALTH NET'S DETAILED DATA SPECIFICATIONS

The following pages provide specifications for every data element used within Health Net's Census Enrollment layout. The data element definitions are designed to provide

characteristics for each field. Please review the following general rules of Health Net’s standard layout:

1. File is to be used to support new enrollments only. Plan changes or add/deletions should not be on this spreadsheet.
2. Health Net’s standard layout does not allow multiple records for the same member. Only one record should be passed for each member in the contract, which should be the current status of the member. Passing more than one record per member will produce inaccurate results.
3. Only Health Net members should be reported on the file (not those of other carriers).
4. For data elements that will not be transmitted to Health Net by your group, the element should be space filled. Please **do not** populate the data elements with fillers such as “0’s” or “9’s”.
5. The Member Type used to identify the employee and each family member should be reported in the following sequence under each SSN: **M**ember, **S**pouse or **P**artner, **D**ependent.
6. Health cannot support effective date corrections via this process. Corrections to Coverage Begin and Coverage End dates must be reported to the Health Net eligibility representative via an alternative method.
7. Group Number assignment will be populated by Health Net.

**New Employees tab:**

Column Letter	Field Name	Field Required	Sample – Refer to Glossary for details
A	Plan Type	Yes	WholeCare HMO
B	Plan Name	Yes	Platinum \$10
C	Dental Plan	Yes	DPPO Classic 4
D	Vision Plan	Yes	PPO Preferred 1025-2
E	Group Term Life - Amount of Coverage	Yes	\$25,000
F & I	Group Term Life - Beneficiary Name	Yes	Mary Smith
G & J	Group Term Life - Beneficiary Relationship	Yes	Mother
H & K	Group Term Life - Beneficiary Percentage	Yes	100% combined
L	Group ID	Fixed	Health Net will complete
M	Activity Flag	Fixed	Fixed Field by Health Net - Add
N	Effective Date	Yes	MMDDYY
O	Employee SSN	Yes	123456789
P	Member SSN / Matricular ID	Yes	123456789

Column Letter	Field Name	Field Required	Sample – Refer to Glossary for details
Q	Member Type	Yes	M, S, P, D
R	Last Name	Yes	Smith Jr
S	First Name	Yes	Carl
T	Middle Initial	No	T
U	Gender	Yes	M, F
V	DOB	Yes	MMDDYY
W	Hire Date	Yes – Sub only	MMDDYY
X	Employee Type (Hourly or Salaried)	Yes	Hourly
Y	Language - Written	No	ENG
Z	Language - Spoken	No	ENG
AA	Disabled	No	Yes, No
AB	Dental HMO Provider ID	No	
AC	Primary Physical Home Address (Address Line 1)	Yes	123 Apple St
AD	Primary Physical Home Address (Address Line 2)	Yes	#15
AE	Primary Physical Home Address (City)	Yes	Ventura
AF	Primary Physical Home Address (State)	Yes	CA
AG	Primary Physical Home Address (Zip)	Yes	93003
AH	Primary Physical Home Address (Zip Plus 4)	No	1234
AI	Telephone Number (Number)	Yes	1234567890
AJ	Telephone Number (Work or Home)	Yes	Work, Home
AK	Email Address	No	Sally@HN.com
AL	Live/Work Rule (HMO) – Use work address?	No	Yes, No
AM	Home Mailing Address (Address Line 1)	No	PO Box 7890
AN	Home Mailing Address (Address Line 2)	No	
AO	Home Mailing Address (City)	No	Ventura
AP	Home Mailing Address (State)	No	CA
AQ	Home Mailing Address (Zip)	No	93003
AR	Home Mailing Address (Zip Plus 4)	No	7890
AS	PCP Last Name	No	Ramos
AT	PCP First Name	No	John
AU	PCP Middle Initial	No	Q
AV	PPG Enrollment ID	Yes	1234
AW	PCP Enrollment ID	Yes	567890
AX	Prior Patient (Yes or No)	Yes	Yes, No
AY	Other Health Coverage (Yes or No)	No	Yes, No
AZ	Other Health Coverage (Carrier Name)	No	Anthem
BA	Other Health Coverage (Start Date)	No	MMDDYY
BB	Other Health Coverage (End Date)	No	MMDDYY

Column Letter	Field Name	Field Required	Sample – Refer to Glossary for details
BC	Medicare Part A	No	Yes, No
BD	Medicare Part B	No	Yes, No
BE	Medicare Parts A & B	No	Yes, No
BF	Medicare Part D	No	Yes, No
BG	Employee Form Signed	Yes	Yes

**Detailed glossary in order of layout element**

**Column A: Plan Type:** Identifies the member’s Product and network type.

**Examples:**

Value
CommunityCare HMO
WholeCare HMO
PPO

**Column B: Plan Name:** This is the plan being enrolled into. **The plan choices are dependent upon the plan type chosen in column A.**

**Column C: Dental Plan:** This is the plan being enrolled into.

**Column D: Vision Plan:** This is the plan being enrolled into.

**Column E: Group Term Life - Amount of Coverage:** The amount of coverage as chosen by the Employer.

**Column F & I: Group Term Life - Beneficiary Name:** The beneficiary name for the Group Term Life. Only one name can be included. For additional beneficiaries, a change form should be submitted.

**Column G & J: Group Term Life - Beneficiary Relationship:** The beneficiary relationship to the employee.

**Column H & K: Group Term Life - Beneficiary Percentage:** Must equal 100%

**Column L: Group ID:** This is the alpha-numeric ID that Health Net uses to identify the benefits and premium rate for each member. This number will be entered by Health Net.

**Column M: Activity Flag:** Fixed field – new Adds only will be processed.

**Column N: Effective Date:** Effective date of coverage based on the Employer’s effective date.

**Column O: Employee SSN:** The employee’s Social Security Number. This number is used for internal purposes only. A Reference ID will be assigned to the member and used for identification purposes.

**Column P: Member SSN / Matricular ID:** The individual member’s Social Security Number. This number is used for internal purposes only. A Reference ID will be assigned to the member and used for identification purposes. If no social is provided, a generic SSN will be assigned. However, a SSN is required for anyone 44 and older.

**Column Q: Member Type:** The alpha code used to identify the member type.

Value
M - Member/Employee
S - Spouse
P - Partner
D - Dependent

**Column R: Last Name:** This is the individual member’s surname and suffix (if applicable). Examples: JONES, JONES II, JONES JR, JONES-SMITH, JONES SMITH.

**Column S: First Name:** This is the member’s first name. The middle initial should not be reported in this field.

**Column T: Middle Initial:** First letter or member’s middle name. The middle initial should not be reported in the first name field. This field may be left blank.

**Column U: Gender:** Identifying sex of individual member. The allowable values are: M = Male, F = Female.

**Column V: DOB:** The member’s birth date. Future dates should not be reported in this field.

**Column W: Hire Date:** Date of Hire or Rehire.

**Column X: Employee Type:** Hourly or Salary

**Column Y: Language – Written:**

Sample of Allowable Values	
AFR	Africans
ARB	Arabic
ARM	Armenian
BLG	Bulgarian
BUR	Burmese
CAM	Cambodian
CAN	Cantonese
ENG	English
FRN	French
GER	German
HBR	Hebrew
HDI	Hindi
HMG	Hmong

Sample of Allowable Values	
JPN	Japanese
MAN	Mandarin
PSH	Pashtu
PUN	Punjabi
RUS	Russian
SPN	Spanish
TAG	Tagalog
TAI	Taiwanese
VTN	Vietnamese
BLANK	Unknown

**Column Z: Language – Spoken:** see table above

**Column AA: Disabled:** This Yes/No value indicates whether or not the member is disabled. The allowable values are Yes, No, or blank.

**Column AB: Dental HMO Provider ID:** The provider ID of the Dentist.

**Column AC: Primary Physical Home Address (Address 1):** The member’s street address.

**Column AD: Primary Physical Home Address (Address 2):** This address line is used for overflow from Address Line 1. Typically used for apartment or unit numbers.

**Column AE: Primary Physical Home Address (City):** The member’s city of residence.

**Column AF: Primary Physical Home Address (State):** The member’s state of residence.

**Column AG: Primary Physical Home Address (Zip Code):** The 5-digit zip code assigned to specific addresses by the United States Postal Service.

**Column AH: Primary Physical Home Address (Zip Plus 4):** The 4-digit zip code extension assigned to specific addresses by the United States Postal Service to assist in accurate and timely delivery of materials.

**Column AI: Telephone Number:** The enrollee’s Telephone Number of choice.

**Column AJ: Telephone Number (Work or Home):** Indicate that the number listed in column AI is work or home.

**Column AK: Email Address:** The enrollee’s email address.

**Column AL: Live/Work Rule(HMO) – Use Work Address?:** Anyone requesting an HMO plan that live beyond the service area may utilize the work address within the service to qualify for the plan. Indicate Yes if you want to use the work address.

**Column AM: Home Mailing Address (Address 1):** The member’s address for mailing purposes.



**Column AN: Home Mailing Address (Address 2):** This address line is used for overflow from Address Line 1. Typically used for apartment or unit numbers.

**Column AO: Home Mailing Address (City):** The member's city of residence for mailing.

**Column AP: Home Mailing Address (State):** The member's state of residence.

**Column AQ: Home Mailing Address (Zip Code):** The 5-digit zip code assigned to specific addresses by the United States Postal Service.

**Column AR: Home Mailing Address (Zip Plus 4):** The 4-digit zip code extension assigned to specific addresses by the United States Postal Service to assist in accurate and timely delivery of materials.

**Column AS: PCP Last Name:** The last name or surname of a member's physician.

**Column AT: PCP First Name:** The first name of a member's physician.

**Column AU: PCP Middle Initial:** The first letter of a physician's middle name

**Column AV: PPG Enrollment ID:** This is the first 4 digits in the identification number assigned by Health Net to the member's medical group. This number can be obtained either from a Health Net Provider Directory or from the physician search feature at [www.healthnet.com](http://www.healthnet.com). Example: 1234567890. Codes from other carriers cannot be utilized.

**Column AW: PCP Enrollment ID:** This is the last 6 digits in the identification number assigned by Health Net to the member's medical group. This number can be obtained either from a Health Net Provider Directory or from the physician search feature at [www.healthnet.com](http://www.healthnet.com). Example: 1234567890. Codes from other carriers cannot be utilized.

**Column AX: Prior Patient (Yes or No):** New enrollee is an existing patient of the physician reported on the electronic file. The allowable values are Y, N, or blank.

**Column AY: Other Health Coverage:** Yes or No if enrollee has other health insurance coverage.

**Column AZ: Other Health Coverage (Carrier Name):** The Carrier name of the "other health coverage".

**Column BA: Other Health Coverage (Start Date):** Date coverage started with other carrier indicated.

**Column BB: Other Health Coverage (End Date):** Date coverage ending with other carrier indicated.

**Column BC: Medicare Part A:** This Yes/No value indicates whether a member has Medicare Part A only. The allowable values are Yes, No, or blank.

**Column BD: Medicare Part B:** This Yes/No value indicates whether a member has Medicare Part B only. The allowable values are Yes, No, or blank.

**Column BE: Medicare Parts A & B:** This Yes/No value indicates whether a member has both Medicare Parts A & B. The allowable values are Yes, No, or blank.

**Column BF: Medicare Part D:** This Yes/No value indicates whether a member has chosen Medicare Part D coverage. The allowable values are Yes, No, or blank.

**Column BG: Employee Form Signed:** Validate and indicate yes that the Enrollment Form has been signed.

**Waivers tab:**

Column Letter	Field Name	Field Required	Sample – Refer to Glossary for details
A	Group ID	Fixed	Health Net will complete
B	Activity Flag	Fixed	Fixed Field by Health Net - Decline
C	Product	Yes	Medical, Dental, Vision
D	Employee Form Signed	Yes	Yes
E	Employee Last Name	Yes	Jones
F	Employee First Name	Yes	Sally
G	Employee SSN	Yes	123456789
H	Member Type Waiving Coverage	Yes	M, S, P, D
I	Last Name of Person Waiving Coverage	No	Jones
J	First Name of Person Waiving Coverage	No	Charles
K	Declination Reason – Standard Reasons	Yes	Valid - Other group coverage through another employer
L	Declination Reason - Other	No	Only required if “other” is selected in column K

**Detailed glossary in order of layout element**

**Column A: Group ID:** This is the alpha-numeric ID that Health Net uses to identify the benefits and premium rate for each member. This number will be entered by Health Net.

**Column B: Activity Flag:** Automatically set by Health Net to “decline”.

**Column C: Product:** The product type that is being waived: Medical, dental, vision, or a combination.

**Column D: Employee Form Signed:** Validate and indicate yes that the Enrollment Form has been signed.

**Column E: Employee Last Name:** This is the employee’s surname and suffix (if applicable). Examples: JONES, JONES II, JONES JR, JONES-SMITH, JONES SMITH.

**Column F: Employee First Name:** This is the employee’s first name.

**Column G: Employee SSN:** The employee’s Social Security Number. This number is used for internal purposes only. A Reference ID will be assigned to the member and used for identification purposes.

**Column H: Member Type Waiving Coverage:** The alpha code used to identify the member type.

Value
M - Member/Employee
S – Spouse of
P – Partner of
D – Dependent of

**Column I: Last Name of Person Waiving Coverage:** This is the individual member’s surname and suffix (if applicable) that is waiving coverage. Examples: JONES, JONES II, JONES JR, JONES-SMITH, JONES SMITH.

**Column J: First Name of Person Waiving Coverage:** This is the member’s first name that is waiving coverage.

**Column K: Declination Reason – Standard Reasons:**

Value
Valid - Other group coverage through another employer
Valid - Group coverage through a spouse/domestic partner on or off the Exchange
Valid - Spousal/domestic partner coverage through the same employer
Valid – Group coverage through a parents plan
Valid - Medicare
Valid - Medi-Cal
Valid - Medicaid
Valid - COBRA
Valid - Union employee covered through a labor fund
Valid – Tricare
Valid – VA
Valid - Active Military Duty
Valid - Individual coverage on or off the Exchange
Non Valid - Coverage with another health insurer through the same employer on or off the Exchange
Non Valid - Religious reasons
Non Valid - Can't afford it
Non Valid - Doesn't want it
Non Valid - Doesn't care
Non Valid - Coverage through an association
Non Valid - Other

**Column L: Declination Reason – Other:** Indicate reason if not captured in Column K.

**COBRA tab:**

Column Letter	Field Name	Field Required	Sample – Refer to Glossary for details
A	Plan Type	Yes	WholeCare HMO
B	Plan Name	Yes	Platinum \$10
C	Dental Plan	Yes	DPPO Classic 4
D	Vision Plan	Yes	PPO Preferred 1025-2
E	Group ID	Fixed	Health Net will complete
F	Activity Flag	Fixed	Fixed Field by Health Net - Add
G	Effective Date	Yes	MMDDYY
H	Employee SSN	Yes	123456789
I	Member SSN / Matricular ID	Yes	123456789
J	Member Type	Yes	M, S, P, D
K	Last Name	Yes	Smith Jr
L	First Name	Yes	Carl
M	Middle Initial	No	T
N	Gender	Yes	M, F
O	DOB	Yes	MMDDYY
P	Hire Date	Yes – Sub only	MMDDYY
Q	Qualifying Event	Yes	
R	Qualifying Date	Yes	MMDDYY
S	<del>COBRA Effective Date</del>	Yes	MMDDYY
T	COBRA End Date	Yes	MMDDYY
U	Employee Type (Hourly or Salaried)	Yes	Hourly
V	Language - Written	No	ENG
W	Language - Spoken	No	ENG
X	Disabled	No	Yes, No
Y	Dental HMO Provider ID	No	
Z	Primary Physical Home Address (Address Line 1)	Yes	123 Apple St
AA	Primary Physical Home Address (Address Line 2)	Yes	#15
AB	Primary Physical Home Address (City)	Yes	Ventura
AC	Primary Physical Home Address (State)	Yes	CA
AD	Primary Physical Home Address (Zip)	Yes	93003
AE	Primary Physical Home Address (Zip Plus 4)	No	1234
AF	Telephone Number (Number)	Yes	1234567890
AG	Telephone Number (Work or Home)	Yes	Work, Home
AH	Email Address	No	Sally@HN.com
AI	Live/Work Rule (HMO) – Use Work Address?	No	Yes, No
AJ	Home Mailing Address (Address Line 1)	No	PO Box 4568
AK	Home Mailing Address (Address Line 2)	No	

Column Letter	Field Name	Field Required	Sample – Refer to Glossary for details
AL	Home Mailing Address (City)	No	Ventura
AM	Home Mailing Address (State)	No	CA
AN	Home Mailing Address (Zip)	No	93003
AO	Home Mailing Address (Zip plus 4)	No	4568
AP	PCP Last Name	No	Ramos
AQ	PCP First Name	No	John
AR	PCP Middle Initial	No	Q
AS	PPG Enrollment ID	Yes	1234
AT	PCP Enrollment ID	Yes	567890
AU	Prior Patient (Yes or No)	Yes	Yes, No
AV	Other Health Coverage (Yes or No)	No	Yes, No
AW	Other Health Coverage (Carrier Name)	No	Anthem
AX	Other Health Coverage (Start Date)	No	MMDDYY
AY	Other Health Coverage (End Date)	No	MMDDYY
AZ	Medicare Part A	No	Yes, No
BA	Medicare Part B	No	Yes, No
BB	Medicare Part A & B	No	Yes, No
BC	Medicare Part D	No	Yes, No
BD	Employee Form Signed	Yes	Yes

**Detailed glossary in order of layout element**

**Column A: Plan Type:** Identifies the member’s Product and network type.

**Examples:**

Value
CommunityCare HMO
WholeCare HMO
PPO

**Column B: Plan Name:** This is the plan being enrolled into. **The plan choices are dependent upon the plan type chosen in column A.**

**Column C: Dental Plan:** This is the plan being enrolled into.

**Column D: Vision Plan:** This is the plan being enrolled into.

**Column E: Group ID:** This is the alpha-numeric ID that Health Net uses to identify the benefits and premium rate for each member. This number will be entered by Health Net.

**Column F: Activity Flag:** Fixed field – new Adds only will be processed.

**Column G: Effective Date:** Effective date of coverage based on the Employer’s effective date.

**Column H: Employee SSN:** The employee's Social Security Number. This number is used for internal purposes only. A Reference ID will be assigned to the member and used for identification purposes.

**Column I: Member SSN / Matricular ID:** The individual member's Social Security Number. This number is used for internal purposes only. A Reference ID will be assigned to the member and used for identification purposes. If no social is provided, a generic SSN will be assigned. However, a SSN is required for anyone 44 and older.

**Column J: Member Type:** The alpha code used to identify the member type.

Value
M - Member/Employee
S - Spouse
P - Partner
D - Dependent

**Column K: Last Name:** This is the individual member's surname and suffix (if applicable). Examples: JONES, JONES II, JONES JR, JONES-SMITH, JONES SMITH.

**Column L: First Name:** This is the member's first name. The middle initial should not be reported in this field.

**Column M: Middle Initial:** First letter or member's middle name. The middle initial should not be reported in the first name field. This field may be left blank.

**Column N: Gender:** Identifying sex of individual member. The allowable values are: M = Male, F = Female.

**Column O: DOB:** The member's birth date. Future dates should not be reported in this field.

**Column P: Hire Date:** Date of Hire or Rehire.

**Column Q: Qualifying Event:** Indicate the event that qualified the member for COBRA.

**Column R: Qualifying Date:** The date the qualifying event occurred.

**Column S: ~~COBRA Effective Date;~~ The date the member's COBRA coverage was effective.**

**Column T: COBRA End Date:** The date the member's COBRA coverage ends.

**Column U: Employee Type:** Hourly or Salary

**Column V: Language – Written:**

Sample of Allowable Values	
AFR	Africans
ARB	Arabic
ARM	Armenian
BLG	Bulgarian
BUR	Burmese
CAM	Cambodian
CAN	Cantonese
ENG	English
FRN	French
GER	German
HBR	Hebrew
HDI	Hindi
HMG	Hmong
JPN	Japanese
MAN	Mandarin
PSH	Pashtu
PUN	Punjabi
RUS	Russian
SPN	Spanish
TAG	Tagalog
TAI	Taiwanese
VTN	Vietnamese
BLANK	Unknown

**Column W: Language – Spoken:** see table above

**Column X: Disabled:** This Yes/No value indicates whether or not the member is disabled. The allowable values are Yes, No, or blank.

**Column Y: Dental HMO Provider ID:** The provider ID of the Dentist.

**Column Z: Primary Physical Home Address (Address 1):** The member’s street address.

**Column AA: Primary Physical Home Address (Address 2):** This address line is used for overflow from Address Line 1. Typically used for apartment or unit numbers.

**Column AB: Primary Physical Home Address (City):** The member’s city of residence.

**Column AC: Primary Physical Home Address (State):** The member’s state of residence.

**Column AD: Primary Physical Home Address (Zip Code):** The 5-digit zip code assigned to specific addresses by the United States Postal Service.

**Column AE: Primary Physical Home Address (Zip Plus 4):** The 4-digit zip code extension assigned to specific addresses by the United States Postal Service to assist in accurate and timely delivery of materials.

**Column AF: Telephone Number (Number):** The enrollee's Telephone Number of choice.

**Column AG: Telephone Number (Work or Home):** Indicate that the number listed in column AF is work or home.

**Column AH: Email Address:** The enrollee's email address.

**Column AI: Live/Work Rule (HMO) – Use Work Address? :** Anyone requesting an HMO plan that live beyond the service area may utilize the work address within the service to qualify for the plan. Indicate Yes if you want to use the work address.

**Column AJ: Home Mailing Address (Address 1):** The member's address for mailing purposes.

**Column AK: Home Mailing Address (Address 2):** This address line is used for overflow from Address Line 1. Typically used for apartment or unit numbers.

**Column AL: Home Mailing Address (City):** The member's city of residence for mailing.

**Column AM: Home Mailing Address (State):** The member's state of residence.

**Column AN: Home Mailing Address (Zip Code):** The 5-digit zip code assigned to specific addresses by the United States Postal Service.

**Column AO: Primary Physical Home Mailing Address (Zip Plus 4):** The 4-digit zip code extension assigned to specific addresses by the United States Postal Service to assist in accurate and timely delivery of materials.

**Column AP: PCP Last Name:** The last name or surname of a member's physician.

**Column AQ: PCP First Name:** The first name of a member's physician.

**Column AR: PCP Middle Initial:** The first letter of a physician's middle name

**Column AS: PPG Enrollment ID:** This is the identification number assigned by Health Net to the member's medical group. This number can be obtained either from a Health Net Provider Directory or from the physician search feature at [www.healthnet.com](http://www.healthnet.com). Example: 1234567890. Codes from other carriers cannot be utilized.

**Column AT: PCP Enrollment ID:** This is the identification number assigned by Health Net to the member's medical group. This number can be obtained either from a Health Net Provider Directory or from the physician search feature at [www.healthnet.com](http://www.healthnet.com). Example: 1234567890. Codes from other carriers cannot be utilized.

**Column AU: Prior Patient (Yes or No):** New enrollee is an existing patient of the physician reported on the electronic file. The allowable values are Y, N, or blank.



**Column AV: Other Health Coverage:** Yes or No if enrollee has other health insurance coverage.

**Column AW: Other Health Coverage (Carrier Name):** The Carrier name of the “other health coverage”.

**Column AX: Other Health Coverage (Start Date):** Date coverage started with other carrier indicated.

**Column AY: Other Health Coverage (End Date):** Date coverage ending with other carrier indicated.

**Column AZ: Medicare Part A:** This Yes/No value indicates whether a member has Medicare Part A only. The allowable values are Yes, No, or blank.

**Column BA: Medicare Part B:** This Yes/No value indicates whether a member has Medicare Part B only. The allowable values are Yes, No, or blank.

**Column BB: Medicare Parts A & B:** This Yes/No value indicates whether a member has both Medicare Parts A & B. The allowable values are Yes, No, or blank.

**Column BC: Medicare Part D:** This Yes/No value indicates whether a member has chosen Medicare Part D coverage. The allowable values are Yes, No, or blank.

**Column BD: Employee Form Signed:** Validate and indicate yes that the Enrollment Form has been signed.