



Claim Status Inquiry Best Practices

Document Revision History

Version	Date	Author	Description
1	August 17, 2004	AnnMarie Errico	Document Created – Version 1
2	January 3, 2005	Sira Cormier	Minor format changes

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Purpose

NEHEN is publishing this Claim Status Inquiry Best Practice guide to assist our Members in understanding the Claim Status EDI transaction, the options available to NEHEN Members for implementing this transaction and the best practices for Claim Status Inquiry as provided by NEHEN Payers, Providers, and Program Management.

Claim Status Overview

The NEHEN technology is designed to send and receive the HIPAA designated standard for the Health Care Claim Status Request and Response: ASC X12N 276/277 (004010X093A1).

The Health Care Claim Status Request (276) is used by health care providers to obtain the current status of a claim within the adjudication process. The request includes information necessary for the payer to identify the specific claim in question.

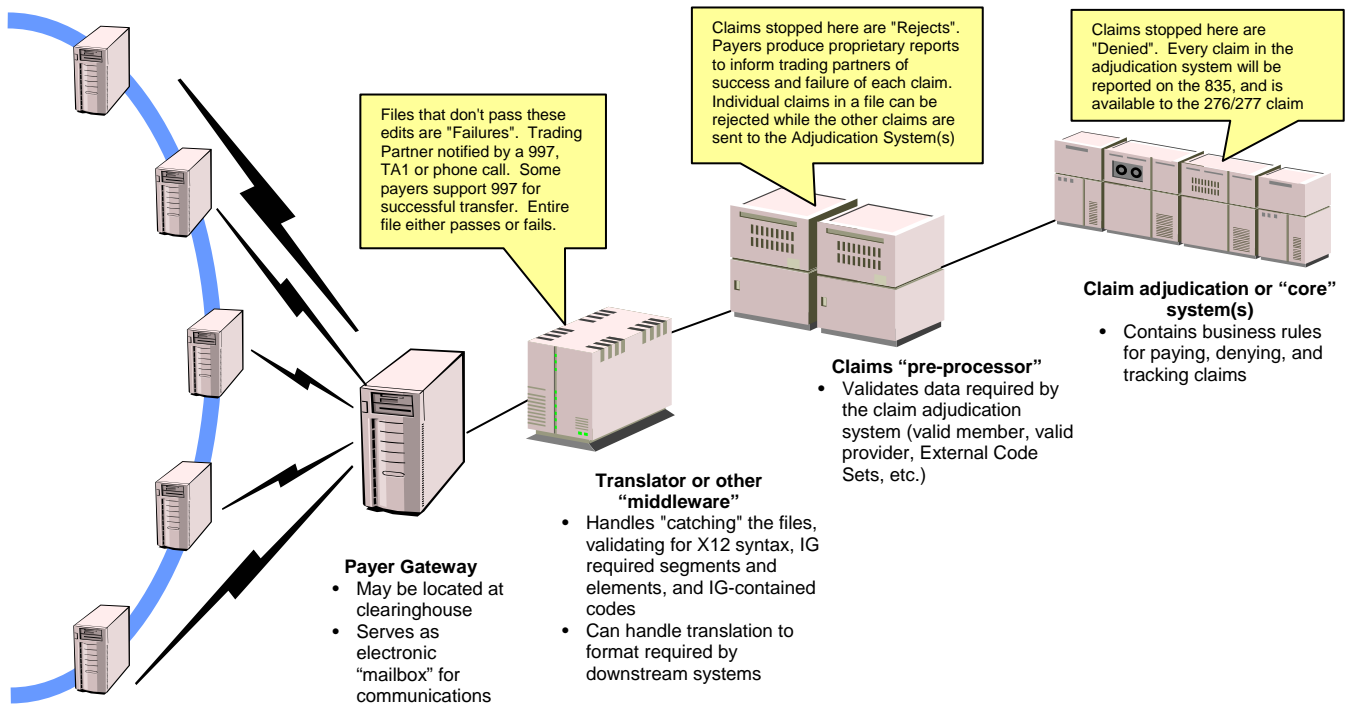
The Health Care Claim Status Response (277) is used by the payer to transmit the current status within the adjudication process to the requester. When the 276 does not uniquely identify the claim within the payer's system, the response may include multiple claims that meet the identification parameters supplied by the requester.

Generally, Payers are able to respond using the 277 transaction after the claim has been accepted into the Payers claim processing or adjudication system.

Prior to acceptance, each claim is reviewed for data that will allow the payer to apply its claim processing rules. The things that are evaluated during this pre-processing phase are Member Number, Provider Number, CPT/Diagnosis Code. If any of these items are in error, the claim cannot be processed and is rejected by the payer. If providers submit claims directly to the payer, payers notify providers using a proprietary submitter/response report when the claim is rejected or accepted. If providers submit claims through a clearinghouse, the payer notifies the clearinghouse of accepted and rejected claims and the clearinghouse notifies the provider.

Payers do not consider a claim to be "filed" according to timely filing rules until it is accepted into the adjudication system. The diagram below describes the edit stages a claim must pass through prior to adjudication.

Payer Edit Workflow and Terminology



Claim Status Request Required Fields

The 276 EDI transaction guide dictates the required fields for the Claims Status Request. The NEHEN technology, by design, uses EDI to send and receive transactions between providers and payers. Many payer web sites do not use the HIPAA standard EDI and therefore have different requirements for submitting a claim status request. The following is the list of required fields for the 276 EDI Claim Status Request.

- ◆ Provider Name
- ◆ Provider ID (Payer Issued)
- ◆ Patient Last Name
- ◆ Policy Number/Member ID
- ◆ Date of Birth
- ◆ Gender
- ◆ Date of Service

Claim Status Response

The payers respond with two levels of status to a claim status request. The first level or *Category Code* indicates whether a claim is “paid”, “pending”, “denied” or “not found”. The second level or *Status Code* includes additional detail such as “awaiting payment cycle”, “accepted for further processing” or “no authorization”.

Below is a partial list of Category and Status Codes. The complete list is included in the Health Care Claim Status Request and Response: ASC X12N 276/277 (004010X093A1) Implementation Guide available at the Washington Publishing Corporation web site: www.wpc-edi.com.

277 Response Codes

◆ Category Codes

- ◆ A4 – Acknowledgement/Not Found
- ◆ A2 – Acknowledgement/Acceptance into Adjudication System
- ◆ E0 – Error in Submitted Request
- ◆ E1 – Response not Possible
- ◆ F0 – Finalized
- ◆ F2 – Finalized/Denial
- ◆ P1 – Pending/In Process

◆ Status Codes

- ◆ 0 – Cannot provide further status electronically
- ◆ 3- Claim adjudicated – awaiting payment cycle
- ◆ 8 – No Payment due to contract/plan provisions
- ◆ 20 – Accepted for further processing.

There are many Category and Status codes but most payers do not use all the codes. To understand a specific payer’s use of the codes, consult the payer’s Companion Guide to the 276/277. The Companion Guides can be found at the payer’s web site.

NEHEN Technology

The NEHEN technology allows members to send standard requests and receive claim status information from other NEHEN members and non-NEHEN members supporting the 276/277 claim status transaction. The following components are used to format and route claim status transactions using NEHEN.

e-Gateway validates that transactions are in standard EDI format and transports transactions between a provider and a payer. The e-Gateway supports both real time transactions and batches. It is used to route transaction to and from stand-alone applications as well as transactions generated from a member's core information systems.

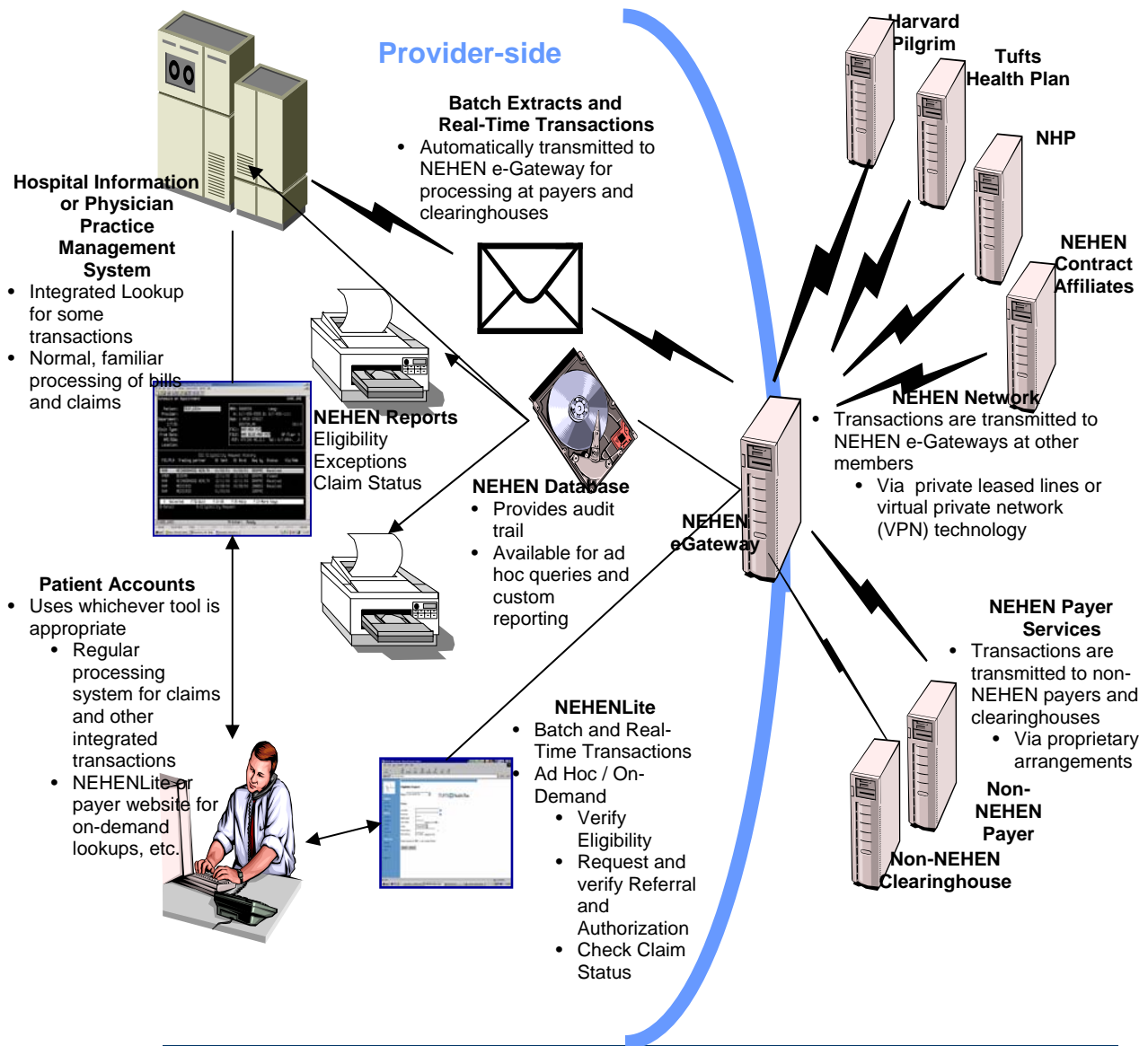
NEHENLite is a web-based application that allows NEHEN members to interactively send transactions and receive and review responses.

NEHEN "Core" is a set of programs and services that format a simple comma separated file into a standard EDI transaction. NEHEN provides the specification. This functionality is used to send batches of transactions to payers. It is also used to map non-standard transactions into standard transactions.

NEHEN Database stores inquiry and response information that is used to display information in NEHENlite and can be accessed for customized reports.

Network Connections are necessary in order to use NEHEN technology. To send and receive transactions, a provider must have a way to connect to a payer. NEHEN supports many connectivity options including Frame Relay, Virtual Private Network (VPN) and Web Services.

NEHEN Technology Overview



NEHEN Payers

NEHEN Members may use the NEHEN technology to send HIPAA Standard EDI transactions to NEHEN Payers and Non-NEHEN Payers alike. NEHEN Payers use the NEHEN technology to route transactions back to providers and also deliver additional electronic information such as Claim Response Reports.

NEHEN Payers work together to provide a common approach to using transactions in order to simplify the process for NEHEN Providers. NEHEN Payers participate in the NEHEN planning process and decided together to develop EDI transactions well in advance of the HIPAA deadlines to allow both providers and payers to benefit from the move to EDI technology.

Note: At this time, NEHEN only supports Claim Status Inquiry to NEHEN Payers. Claim Status Inquiry to MassHealth (Medicaid) and Proxymed Payers is in development. Other payers will be developed based on NEHEN Member priorities.

NEHEN Payer Members:

- ◆ Harvard Pilgrim Health Care
- ◆ Neighborhood Health Plan of Massachusetts
- ◆ Network Health
- ◆ Tufts Health Plan

NEHEN Contract Affiliates work with NEHEN Program Management to provide added value services to our members. **Proxymed** is a NEHEN contract affiliate that allows access to additional payers for eligibility verification and other EDI transactions such as claims.

Proxymed Payers:

- ◆ Aetna
- ◆ Cigna
- ◆ Other-(Oxford, Anthem....)
- ◆ www.Proxymed.com for the complete list of payers

NEHEN Program Management also develops services to send and receive electronic transaction between Non-member Payers that are significant parts of NEHEN Providers' payer mix. These include government payers such as Medicare and Medicaid and commercial non-NEHEN payers such as Blue Cross of Massachusetts. Please note that NEHEN Members must have a contract with WebMD to access BCBSMA.

Other Payers Supported:

- ◆ MassHealth – Medicaid -
- ◆ Medicare - **Proprietary Eligibility only*
- ◆ BCBSMA - *** (requires WebMD contract)*

Claim Status Inquiry Options

NEHEN Members have three basic options for implementing claim status inquiry: Interactive Real Time (stand-alone), Batch, and Integrated into their core information systems. The NEHEN technology supports all three options.

Interactive real time – Stand-alone

Using stand-alone interactive real time claim status inquiry, the provider uses an application separate from the billing system to inquire on the status of a claim. NEHEN Members can use the intranet web application **NEHENLite** to access multiple payers from a single site and do individual claim status checks. Many providers also use individual payer websites or other commercial products to do real-time claim status inquiry.

Stand-alone claim status applications are an improvement over making telephone calls or not checking claim status at all and they are relatively quick and inexpensive to implement. However, this type of application requires a user to type in each request and to log into another system to update the response information.


This option for checking claim status is best for getting up and running quickly while development is completed on more automated or integrated methods. It is also useful in areas where access to core systems is not available such as remote offices.

Claim Status Options: Interactive Real Time - NEHENLite Claim Status Request and Response

NEHEN Online System - Microsoft Internet Explorer

Address: http://127.0.0.1/neh/en/

Claim Status Request

Payer: Harvard Pilgrim Healthcare 

Service Provider

Institution or Last Name: Last Name:

First Name: First Name:

Provider ID: 900067 (Payer) Policy Number:

Date of Birth: (MMDDCCYY)

Gender: Unspecified



Patient

Account Number:

Payer Claim ID:

Dates of Service From: - To:

Claim Amount:

Fields indicated by  or  are required fields.

NEHEN Online System - Microsoft Internet Explorer

Address: http://127.0.0.1/neh/en/

Claim Status Response

Member: SPEARS (hp456922204) Provider: Children's Hospital (900018), DOS: 12/08/2000-12/08/2000

Subscriber: TRACY L JONES, ID: hp456922200, DOB: 09/28/1967
 Patient: BRITNY M SPEARS, ID: hp456922204, DOB: 06/17/1990

Primary Status:
Finalized/Payment (F1)

Payer Claim ID	Charge Amount	Paid Amount	Claim Dates of Service	Status Date	Check Number	Check Date
001222XH0137	11429.99	4544	12/08/2000-12/08/2000	12/26/2000		

Lines

Primary Status	Line ID	Procedure Code	Line Charge Amount	Paid Amount	Quantity	Status Date	Other Status 1	Other Status 2
Finalized/Payment (F1) - PAID AT CONTRACTED RATE-PNT LIABLE FOR COPAY/DEDUCTIBLE/CO-INSURANCE (03)	01	ZZ:04	5408	4544	4	12/26/2000		
Finalized/Denial (F2) - CLAIMS HISTORY/INFORMATION ONLY/PER DIEM/FIXED PRICE. (07)	02	ZZ:73D	6021.99	0	1	12/26/2000		

Batch

NEHEN members use Batch Claim Status Inquiry to inquire on multiple claims without doing the data entry. The business process takes place behind the scenes, in the background, by the computer.

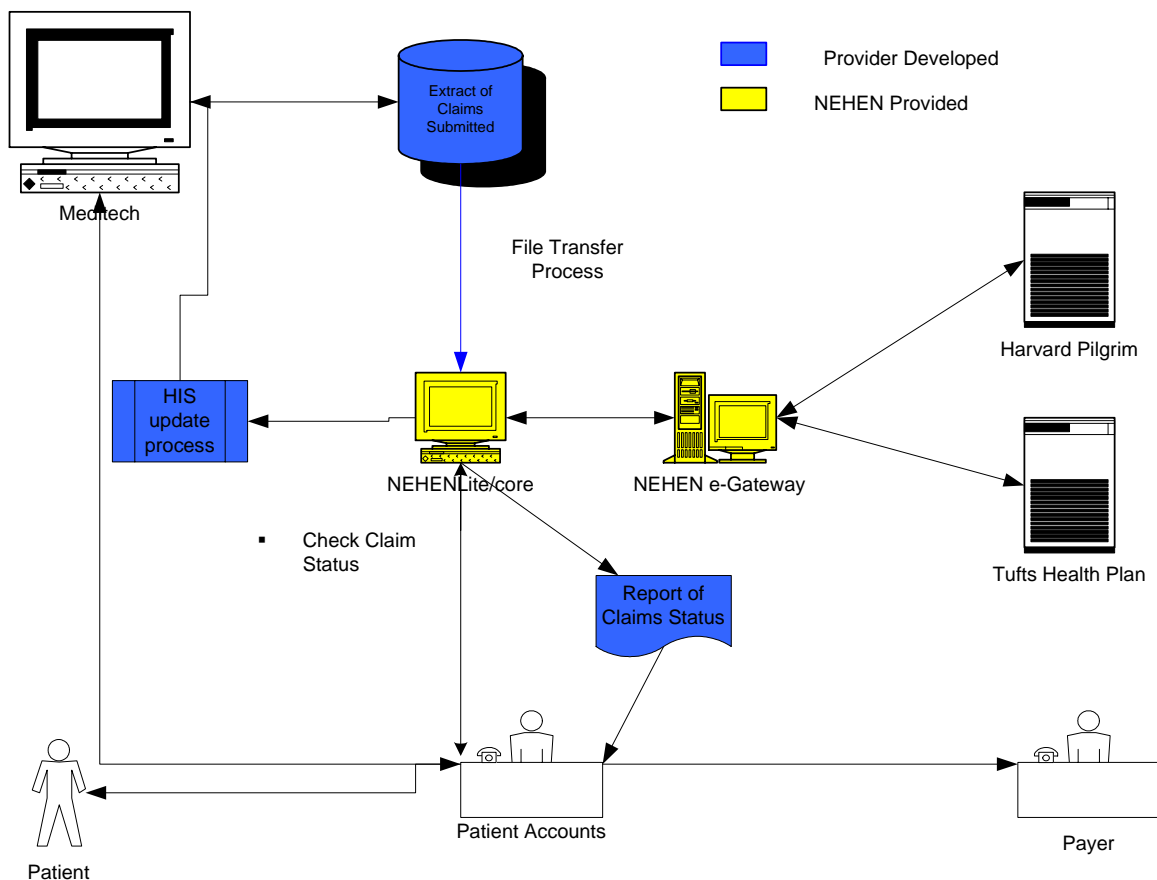
An extract of the required data for the claim status inquiry transaction is taken from the billing system. This data is formatted as individual EDI transactions and then sent to the payer. The responses are returned and stored for later reporting.

NEHEN supports this option for claim status inquiry by allowing providers to format the inquiries in simple “flat file” format. The NEHEN core technology takes the file and formats the EDI transactions. Each transaction is stored in the NEHEN database and the response is matched and stored when returned by the payer. Providers may then use NEHENLite to view the responses or develop reports out of the stored transactions in the relational database.

Using batch, providers have the ability to increase the number of claim status inquiries performed while reducing the required time and labor. The provider may choose to only work the “statuses” that will result in process improvements.

Implementing a batch option requires changes to existing business processes and requires the provider to invest in the development of extracts, reports, and processes to update the core registration/billing system. NEHEN provides a guide to setting up batch eligibility.

Eligibility Options: Batch Claim Status Inquiry Process



Integrated

Integrated EDI transactions are programmed into the provider’s core Hospital Information System. The system allows real time inquiries as part of the normal workflow or can be automatically programmed to send batches of claims for inquiry. The responses are stored along with all the claim information. Reports are either provided with the system or are easily customizable.

Integrating EDI transactions into core systems is the ideal way to ensure that all information regarding a patient and claim is stored in the same place. It also minimizes the training required.

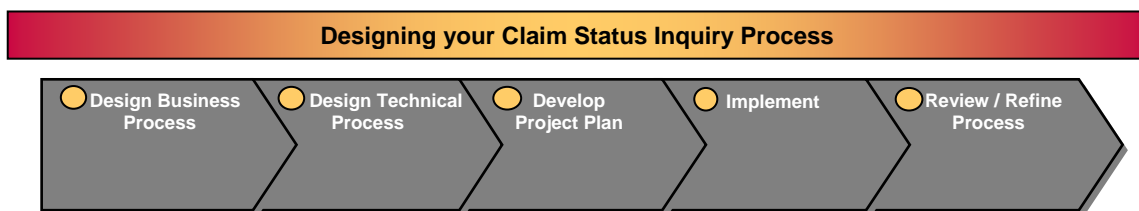
In order to integrate claim status inquiry into a core system, the provider must purchase or develop the additional EDI module for their core system and do customization and/or programming and testing before general use.

Claim Status Inquiry – Deciding Which Options to Implement

Each of the options for implementing claim status inquiry can provide benefits to a provider organization. Since each organization has different business practices and system capabilities, we do not recommend a single process for inquiring on claim status. We encourage NEHEN Members to take advantage of the entire “suite” of options available for checking claim status from integrated to batch to payer websites and to use the best option to support their business processes.

Before implementing any of the claim status options, we encourage providers to design the claim status inquiry process beginning with the business process. Once you have identified how you would like the transaction to work for you, design the technical process. Develop a project plan for implementation and use an iterative approach for development. Implement the transaction, review the process and refine it as necessary.

Designing your Claim Status Inquiry Process



Design the Business Process

Designing the business process or processes, you determine how you want the transaction to work for you. Some of the questions you will want to address are as follows:

- ◆ **What business problem are you trying to solve?**

- ◆ **What is your current business process?**
 - ◆ How do you currently address the business problem?
 - ◆ What would you like to do to address the business problem?
 - ◆ How does the EDI transaction address the business problem?
- ◆ **How would you like to use the transaction?**
 - ◆ What do you want to inquire on
 - ◆ *When do you want to inquire?*
 - ◆ *How often do you want to inquire?*
 - ◆ Where does the information come from?
 - ◆ How do you want to send the transaction?
- ◆ **How would you like to view the responses?**
 - ◆ Which responses do you want to view?
 - ◆ *View responses according to what you are going to do with the information*
 - ◆ Ex: Only view those claims that are denied or not received
 - ◆ In what format do you want to view response?
 - ◆ *Report, on-line, etc.*
- ◆ **What do you want to do with the information after it is received?**
 - ◆ Save it
 - ◆ Update claim in billing/hospital system
- ◆ **What else can this information be used for?**
 - ◆ Can this information be used to do additional analysis in order to solve a business problem?
 - ◆ *Analyze data to determine where claim problems occur*

Design the Technical Process

Once you have determined the business process, you must understand technically how to implement the process given the tools and resources available to you.

- ◆ **What will it take to implement the business process?**
- ◆ **What can your existing systems do?**
- ◆ **What are the tools provided by NEHEN?**
- ◆ **What can be learned from other NEHEN Members?**
- ◆ **What are the abilities/limitations of my trading partners?**

Develop the Project Plan

Plan the project taking into account the resources available. Prioritize and phase in functionality if everything cannot be completed at once. Consider implementing limited functionality first then phase in additional reports or processes such as updating the billing system with the claim status response.

Implement

In addition to phasing in functionality, consider implementing a single payer as a “pilot” to test your new processes. Add a payer and or new functionality after each review process.

Review/Refine Process

Plan to evaluate your implementation after the processes have been used in production and determine enhancements and improvements to the process. Consult with users; gather suggestions, and review results and reports as input for the next iteration of development.

Payer Lessons Learned

Using NEHEN technology, providers get claim status information directly from payer systems. Therefore, there are slight differences among payers. Some differences will be noted in this section as well as other information that will help you understand and use a payer’s response. Providers should review the 276/277 Companion Guides available at payer web sites for additional payer-specific information.

Understand the Payers Response

Payers use a subset of the available standard Category/Status Codes. Familiarize yourself with the most common codes and how the major payers use them. Understanding how the Claim Status Inquiry Codes compare to the codes commonly found on the remittance is also helpful.

A4 - Not Found

One of the most troubling responses is the **A4-Not Found**. This code means that the data provided on the Claim Status Request does not **exactly** match a claim in the payer's system. Although it is possible that the claim is really not in the payer's system, it is also very possible that there was a provider error entering the request or that the payer **changed** something identifying the claim upon loading it in the adjudication system.

Common Reasons for A4/Not Found

- ◆ Incorrect data entered on inquiry
- ◆ Member ID
 - ◆ Terminated Member ID
 - ◆ Member ID “crosswalked”/corrected prior to adjudication
- ◆ Date of Service
 - ◆ Out of Range
 - ◆ Payer changed DOS to match line items
- ◆ Provider
 - ◆ Member claim not for inquiring provider
- ◆ Claim not in Payer system

Resolving A4 – Not Found

Most members determine the reason for A4-Not Found by locating the claim using the payer web sites. The payer web sites are not restricted by the requirements of the HIPAA mandated 276/277 transaction and allow you to search for claims using other identifiers such as the *provider account number*. By comparing the data retrieved from the web site to the request generated using EDI you can see if the Member ID, date of service or something else has been changed so that the EDI request generated from your hospital system does not match the identifying data in the payer system.

If you are unable to find the claim on the web site or you cannot determine why a claim was found on the web site and not with EDI, call the payer for assistance.

Understand how Payers “Change” your Claim

In specific instances, instead of rejecting a claim and returning it to the provider for resubmission, payers modify the claim so that it can be adjudicated.

Correcting Member ID – “crosswalking”

Harvard Pilgrim, Tufts Health Plan and other payers may “crosswalk” or correct a Member ID if it is easy for them to identify the correct one. For example, if you have stored an “old” member id and the payers have it associated with the “current” Member ID, they may change it when they move the claim to the adjudication system. This allows the claim to be adjudicated; however,

when a provider uses the “old” member id to inquire on a claim, the payer will have nothing in their adjudication system that matches the “old” member id.

Another example of crosswalking happens when the Member ID submitted is for a different family member (different suffix) than the submitted name and date of birth. Again, the payer may correct this problem; but once again, when you inquire using the incorrect Member ID in your system, there is no corresponding claim with that Member ID in the payer system.

Ensure that you minimize the A4-Not Found response by checking patient eligibility and updating your system with the correct member ID.

Dates of Service

Another reason for the A4- Not Found response is a date of service on the claim status request that does not match a date of service in the payers adjudication system.

Harvard Pilgrim does not store the date of service submitted at the claim level when it stores a claim in its adjudication system. Harvard Pilgrim derives the date of service from the first date among all the line items for the claim.

When submitting a claim status request for Harvard Pilgrim, program your system to use the earliest line item date as the date of service or enter the earliest line item date if you are doing data entry.

Be Aware of Payer System Availability

Most payers keep their claim status service up 24/7. There are some scheduled downtimes for maintenance. Inform users of the scheduled/unscheduled downtimes for the payers and the procedure to be followed when electronic claim status is unavailable.

If you are planning to submit batches of claim status inquiries, it is usually best to schedule them for times outside of normal business hours. Please notify the payers of your plans and ask for the best time to schedule a batch. Payer contact information is included in the back of this document.

- ◆ Tufts Health Plan performs scheduled maintenance from Wednesday 10:00pm until Thursday 2:00 am.

Provider Best Practices

This section contains helpful hints and lessons learned from the experience of NEHEN Providers and NEHEN Program Management.

Providers get the best results from their Claim Status processes when they have correct patient information in their systems.

Check patient eligibility and record the correct information in your hospital/practice management system to avoid payer “crosswalking” of Member ID and the A4 – Not Found response.

When implementing Claim Status Inquiry use an iterative/pilot approach

Phase in functionality and payers when first implementing Claim Status Inquiry. Evaluate your process before adding enhancements. Testing and working through issues such as A4 – Not

Found takes time but will result in a better implementation. Communicate with other areas such as Patient Access to ensure correct data is entered to prevent problems during billing and collections.

Plan for Unscheduled Downtime

NEHEN Payers are available for eligibility verification and claim status 7 days a week and nearly 24 hours a day. On occasion there is a problem in the network that causes a delay in the response or an “Unable to Respond” response. The problems can occur in the payer’s system, the network connection between the payer and provider, the provider’s core system or the e-Gateway.

Notify the NEHEN Administrator at the provider site to troubleshoot the problem. End users are the first to notice a problem and should report them as soon as possible. The NEHEN Administrator will contact NEHEN Technical Support or the Payer Technical Support if he/she cannot resolve the problem.

Registrars and other end users should have a process for scheduled and unscheduled downtime. They may use the phone, the Internet or identify patients that should be verified later when the systems are available.

NEHEN Queues Transactions

The NEHEN e-Gateway routes transactions between payers and providers. It maintains a queue of requests to each payer and processes the transactions based on when they were received in the queue. Most of the time, the end user is unaware of the queue because responses are returned within seconds of the inquiry.

Occasionally, the queue backs up due to a payer’s gateway being down or another technical issue. If the NEHEN e-Gateway is unable to deliver the transaction, it holds the transaction in the queue and checks constantly to see if it is able to deliver the transactions. Once the payer can receive the transactions and generate a response, the queued transactions are sent and the queue is cleared.

The end user only knows that no response has been received. Re-sending the transaction adds additional transactions to the queue and will delay the time that it takes to return to normal operation.

End users should contact follow their organizations procedure for contacting the on-site NEHEN Administrator to notify him/her of possible issues.

For cases where the end user receives an “Unable to Respond” response, the NEHEN e-Gateway successfully delivered the transaction and it is not longer in the queue. In this case, the payer has received the transaction but the back-end process that processes the transaction may be unavailable as is the case when Medicare is down. The end user must therefore resend the transaction when the payer system is available.

If end users receive the “Unable to Respond” transaction outside of the known Medicare downtime, they should contact he on-site NEHEN Administrator.

Use your claim results to measure how well the Eligibility processes are working

Have you implemented on-line eligibility yet still experiencing large numbers of rejections for invalid Member id/date of birth/invalid name?

Do you have denials for no referral or not your patient?

Keep track of the rejections and denials received in order to pinpoint where eligibility processes may be improved.

Communicate your findings

Follow up with departments/areas where improved processes could produce fewer claim rejections and denials.

Share results with NEHEN Members. Inform NEHEN Payers of discrepancies or issues and remember to keep NEHEN Program Management in the loop.

Claims of Discrepancies of data

Sometime providers claim they get a different response if they use a payer web site vs. their NEHEN connected system. If you encounter a discrepancy between systems, print the screens from each system and highlight the inconsistent data. Document the problem and contact your NEHEN Administrator, NEHEN Technical Support and the Payer Technical Support.

Revenue Cycle e-Transaction Specialist

There are many details to learn in order for organizations to use their NEHEN and other e-transactions effectively. We recommend making it someone's job to understand the business processes and rules surrounding the e-transactions such as eligibility verification and also understand enough of the technical requirements to make recommendations to the organization.

The Revenue Cycle e-Transaction Specialist would have the following responsibilities:

- ◆ **Educate:** Train others on the options and best practices for utilizing the electronic transactions.
- ◆ **Automate:** Use knowledge of the e-transaction technology, options and best practices to automate existing business processes or design new processes to improve results.
- ◆ **Evaluate:** Review the results of existing business processes and make recommendations for improvement.
- ◆ **Communicate:** Assist members of the organization by being the aggregator of lessons learned and best practices. Communicate information internally and externally to payers and NEHEN Members.

Contact and Support Information

NEHEN Members can contact NEHEN technical support or program management if they have questions. Remember that you are connecting directly to payer systems so if you have problems you may want to contact the payer directly.

NEHEN Payer Contact Information

Harvard Pilgrim Healthcare

- www.HarvardPilgrim.org
- Harvard Pilgrim EDI Team
 - o 800-708-4414 (Option 7)
 - o Edi-team@hphc.org

Network Health

- www.Network-Health.org
- EDI Team
 - o 888-257-1985
 - o Peter.Bristol@Network-Health.org

Neighborhood Health Plan

- www.NHP.org
- NHP E-Commerce
 - o 800-43305556
 - o Ecomm@nhp.org

Tufts Health Plan

- www.Tufts-Health.com
- Tufts HP EDI Operations
 - o 888-880-8699 x4042
 - o EDI_Operations@Tufts-Health.com

Please contact NEHEN Directly if you have problems with Medicare, MassHealth/Medicaid or Proxymed Payers.

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NEHEN Website: www.NEHEN.org

The NEHEN website is where NEHEN Members can find useful information for technical support and best practices. These items are found in section titled “Support and Resources”. Here are some of the documents relating to Claim Status Inquiry that can be found on the website:

- ◆ Batch Claim Status Inquiry Setup Document
- ◆ NEHENLite Claim Status Inquiry Training Guide
- ◆ Claim Status Inquiry Best Practices

CSC's Role as the common NEHEN Program Manager

CSC is the coordinator and facilitator for NEHEN, in particular:

- Creating strategy & direction
- Organizing and supporting participant meetings and discussions
- Developing and piloting core technologies
- Coordinating implementation plans
- Resolving implementation issues
- Recruiting new members
- Providing impetus and momentum - keeping the ball rolling

As Program Manager, CSC provides support and guidance to Managers in carrying-out and implementing NEHEN's goals and priorities. CSC is also the Technical Architect responsible for the design, implementation and the technical support of NEHEN's core technologies.

About CSC

Computer Sciences Corporation helps clients achieve strategic goals and profit from the use of information technology.

With the broadest range of capabilities, CSC offers clients the solutions they need to manage complexity, focus on core businesses, collaborate with partners and clients, and improve operations.

CSC makes a special point of understanding its clients and provides experts with real-world experience to work with them. CSC is vendor-independent, delivering solutions that best meet each client's unique requirements.

For more than 40 years, clients in industries and governments worldwide have trusted CSC with their business process and information systems outsourcing, systems integration and consulting needs.

The company trades on the New York Stock Exchange under the symbol "CSC."

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