APPENDIX I.

New Hampshire
Comprehensive Health Information System
(NHCHIS)
Data Submission Instructions
Revised February 2015

Executive Summary

The purpose of this document is to describe the requirements for data submissions to the New Hampshire Comprehensive Health Information System administered jointly by the New Hampshire Insurance Department and the New Hampshire Department of Health and Human Services. This document updates and revises all prior versions of the data submission instructions and provides additional guidance to submitters.

Document history and effective date: The New Hampshire Insurance Department, in conjunction with the New Hampshire Department of Insurance, is issuing this Data Submission Instructions for data required under INS 4000 as revised in February 2015.

This revision includes the following changes and clarifications:

General:

- State-specific code lists have been standardized across all files.
- A provider file is now required.
- Carriers offering Medicare Supplemental ("Medigap") coverage are now required to submit files.
- Denied claims are now to be included in claims files.
- All files must use consistent member and subscriber identifiers to support accurate alignment of member information across files, including files provided by subcontractors such as behavioral health organizations and pharmacy benefit managers. .
- Claims files must include record of service under alternative payment arrangements with zero paid amounts.
- Additional data elements for Medicaid FFS and Medicare Managed Care Organizations.
- New data elements to enhance the use of NHCHIS to validate NHID Supplemental Filing reports, including plan identification numbers, metallic value and plan characteristics information.

Member Eligibility:

- Retrospective Updates: The Member Eligibility file will include information for the reporting month and any retrospective updates that correspond to previously submitted member eligibility records.
- Carriers and third-party administrators that fall below the de minimus threshold must provide 180 days of claims run out for those members.

Medical Claims:

- New data elements are added to improve data quality:
    - Prior claim transaction identification number
    - Additional procedure codes
    - ICD 9 or ICD 10 flag
    - Payment arrangement type to signal capitated or other non FFS payment arrangements
    - Denied claims flag and denied claim reason codes.

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I. Background, purpose and legal authority

A. Purpose

The New Hampshire Comprehensive Health Care Information System (CHIS) was created by New Hampshire state statute to make health care data "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices." The statute also required that the New Hampshire Insurance Department (NHID) and the NH Department of Health and Human Services (NH DHHS) partner on the project. The same legislation that created the CHIS also enacted statutes that mandated that health insurance carriers and third-party administrators submit their de-identified health care claims data and Health Employer Data and Information Set (HEDIS) data to the state. NHID and DHHS will issue separate data submission instructions for Workers Compensation Medical Claims data collection.

B. Legal Authority

In 2005, the New Hampshire State Legislature enacted RSA Chapter 420-G:11-a, directing the NHID and the NH DHHS to create a comprehensive health care information system (CHIS). Initial data collection rules were revised in 2014 to reflect changes in health care claims data structure, including accommodating ICD-10 and providing information to strengthen New Hampshire's rate review process under the Affordable Care Act. The revised rules will appear at INS 4000. INS Section 4005 directs the Department to issue detailed instructions.

C. Schedule for updates to these instructions

1. NHID, DHHS and their designee may add information to these instructions from time to time to correct technical errors or otherwise facilitate data submission.

2. NHID and DHHS intend to limit additions and significant revisions to once per calendar year. A revision includes adding data elements or significantly revising the definitions and formats.

3. NHID, DHHS and their designee will send notifications about revisions and additions to data submitters at the email addresses provided during the annual registration process.

II. Definitions

A. Definitions Included in the Data Submission Instructions

Definitions in this section have the same meaning as INS 4002 and are included here for

data submitters' convenience.

(a) "Address" means street address, post office box numbers, apartment numbers, e-mail addresses, web universal resource locator (URL) and internet protocol (IP) address number.

(b) "Alternative payment arrangements" means those claims considered "paid" by the carrier or third-party administrator under a capitated services arrangement or a global payment, resulting in zero paid amounts on the claim.

(c) "Blanket health insurance" is as defined under RSA 415:18, I-a and means that form of accident and health insurance that is not "health coverage" under RSA 420-G:2, IX, that does not require individual applications from covered persons, and that does not require a carrier or third-party administrator o furnish each person with a certificate of coverage.

(d) "Capitated services" means services rendered by a provider through a contract in which payment is based upon a fixed dollar amount for each member on a monthly basis

(e) "Carrier" means any entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Commissioner that contracts or offers to provide, deliver, arrange for, pay for or reimburse any of the costs of health services, or to administer on behalf of third-party payer and includes an insurance company, a health maintenance organization, a nonprofit health services corporation, a dental benefits administrator, a third-party administrator or any other entity arranging for or providing health coverage, Medicare Advantage plans, and Medicare Supplemental Coverage.

(f) "Commissioner" means the Insurance Commissioner.

(g) "Dental claims file" means a data file composed of service level remittance information for all adjudicated claims for each billed dental service provided to members, including data for services provided under alternative payment arrangements with zero paid amounts.

(h) "Department (NHID)" means the New Hampshire Insurance Department.

(i) "Designee" means an entity with which the Department and/or the Department of Health and Human Services have entered into an arrangement pursuant to which the entity performs data management and collecting functions, and under which the entity is strictly prohibited from using or releasing the information and data obtained in such a capacity for any purposes other than those specified in the agreement.

(j) "DHHS" means the Department of Health and Human Services.

(k) "Direct identifier" means any information, other than case or code numbers used to create anonymous or encrypted data, that plainly discloses the identity of an individual.

(l) "Encryption" means a method by which the true value of data has been disguised in order to prevent the identification of persons or groups, and which does not provide the means for recovering the true value of the data.

(m) "Exchange" means a governmental agency or non-profit entity that meets the applicable standards of 42 U.S.C. section 13031 and makes Qualified Health Plans available to qualified individuals and qualified employers in accordance with federal law.

(n) "Health care claims data" means the set of data files that carriers and third-party administrators must submit that consists of, or is derived directly from, member eligibility, medical claims, pharmacy claims and dental claims files, including a provider file. "Health care claims data" does not include analysis, reports, or studies containing information from health care claims data sets, if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by the Department.

(o) "Hospital" means a licensed acute or specialty care institution.

(p) "Insured" means an individual in whose name an insurance policy is carried.

(q) "Medical claims file" means a data file composed of service level remittance information for all adjudicated claims for each billed medical service provided to members, including data for services provided under alternative payment arrangements with zero paid amounts.

(r) "Members" or "Covered lives" shall include all individuals, employees and dependents for which the health carrier or third-party administrator has an obligation to adjudicate, pay or disburse claim payments. For employer-sponsored group coverage, covered lives shall include certificate holders and their dependents.

(s) "Member eligibility file" means a data file containing demographic information for each individual member eligible for medical pharmacy, or dental benefits for one or more days of coverage at any time during a reporting month as well as any retrospective updates that correspond to previously submitted eligibility data. It should include benefits, attributes and associated effective periods..

(t) "NHCHIS" is the "New Hampshire Comprehensive Health Information System" established and operated by the department and the department of health and human services or their designee to collect, store and analyze health care claims data.

(u) "Pharmacy claims file" means a data file composed of service level remittance information from all adjudicated claims for each billed prescription provided to members, including data for services provided under alternative payment arrangements with zero paid amounts.

(v) “Plan ID” means the 14-character HIOS Plan ID, standard component. This field may not be available for all market segments; input “N/A” where not available. The CMS Health Information Oversight System Plan ID is a 16 character code assigned by CMS. Carriers must register to obtain a product and plan code through the CMS Enterprise Portal. See https://portal.cms.gov/ for additional information. The full HIOS ID is unique to each fully insured carrier/product/plan.

(w) "Plan sponsor" means any persons, other than an insurer, who establishes or maintains a plan covering residents of the state of New Hampshire, including, but not limited to, plans established or maintained by employers or jointly by one or more employers and one or more employee organizations, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the plan.

(x) "Prepaid Amount”" means the amount that would have been paid by the health care claims processor for a specific service if the service had not been capitated, or otherwise did not result in a transfer of funds.

(y) "Provider" means a health care facility, medical, dental, or behavioral health care practitioner, health product manufacturer, health product vendor or pharmacy.

(z) "Provider file” means a data file listing information about the service providers identified in the medical claims, pharmacy claims, and the dental claims file as servicing billing, prescribing, or primary providers.

(aa) “Release" means to make data or information available for inspection and copying to persons other than the data submitter.

(bb) “Subcontractor” means a vendor or contractor who manages carved out categories of services, including behavioral health services, pharmacy services or any other subcontractor that processes claims on behalf of a carrier.

(cc) “Subscriber" means the certificate holder who receives coverage from a carrier or third-party administrator as defined in these rules. For employer-sponsored group coverage, the employee or subscriber shall be the certificate holder. For individual coverage, the policyholder shall be the certificate holder. For other types of group coverage, the certificate holder shall mean the person who is the principal insured.

(dd) "Third party administrator" means any persons licensed by the Department that receives or collects charges, contributions or premiums for, or adjusts or settles claims for residents of the state, on behalf of a plan sponsor, health care services plan, dental services plan, nonprofit hospital or medical service organization, health maintenance organization or insurer.

III. Registration Requirements for all Carriers and Third-Party Administrators

A. Requirements

1. All carriers and third-party administrators must register annually by March 15 of every calendar year through a form available on the CHIS website.

2. Carriers and third-party administrators shall notify the Department's designee within 30 days of changes to any of the information provided to the Department's designee during the annual registration process.

3. Carriers and third-party administrators shall notify the Department's designee of any changes to the individual contact information as soon as possible, but no later than 30 days after a reassignment occurs.

B. The registration form contains the following fields:

Company Name
Company Name Mailing Address
Company Name City
Company Name State
Company Name Zip
Submitter Last Name, First Name
Submitter Email
Submitter Phone
Date of submission
Compliance/Government Affairs Last Name, First Name
Compliance/Government Affairs Email
Compliance/Government Affairs Phone
Alternate Contact 1 Last Name, First Name
Alternate Contact 1 Office and Title
Alternate Contact 1 Email
Alternate Contact 1 Phone
Alternate Contact 2 Last Name, First Name
Alternate Contact 2 Office and Title
Alternate Contact 2 Email
Alternate Contact 2 Phone
Line of Business: Comprehensive Medical/Medicare Supplemental/Dental only/pharmacy
Health Insurance In State (Y/N)
Payer with Premiums over $250,000 (Y/N)
Administrator with more than 200 NH Covered Lives (Y/N)
Month of this report: MMYY
Estimated Number of Covered Lives for month of this report
Estimated Number of Medicare Supplemental Covered Lives in month of this report
Data File Type

Payer Code
Sub-Company/Separate Submission Platforms
Eligibility Payer Code
Sub-Code
Last Update
Submitter Receives: Data Submission Notifications, Data Submission Reports, Newsletters, SFTP Account Information, Access to the Report Portal
Compliance/Government Affairs Receives: Data Submission Notifications, Data Submission Reports, Newsletters, SFTP Account Information, Access to the Report Portal
Alternate Contact 1 Receives: Data Submission Notifications, Data Submission Reports, Newsletters, SFTP Account Information, Access to the Report Portal
Alternate Contact 2 Receives: Data Submission Notifications, Data Submission Reports, Newsletters, SFTP Account Information, Access to the Report Portal

C. Carriers and third-party administrators shall submit this form through the NHCHIS website:
https://nhchis.com/NH/Account/Login?ReturnUrl=%2fNH%2fAccount%2fRegistrationSelect

IV. Data Submission Timelines

A. Filing Periods and Schedule for Data Submissions. The deadline for submitting data files shall be determined by the total number of members for whom claims are being paid or processed by each carrier or third-party administrator

1. Carriers and third-party administrators that have 10,000 or more New Hampshire members shall submit required files no later than 30 calendar days after the close of the reporting month.

2. Carriers and third-party administrators that have fewer than 10,000 New Hampshire members, but do not meet the de minimis exclusion in Ins 4005.02, shall submit required files quarterly no later than 30 calendar days after the end of the reporting quarter.

3. First Time Submitters. Carriers and third-party administrators that have not previously submitted files to the Department and DHHS or their designee and that have never registered under this rule shall register no later than 30 days after the effective date of such coverage in the state. First-time submitters shall register using a form provided by the designee and shall provide test files within (120 Days) after registration. The test files shall correspond to the size required for that carrier or third-party administrator as specified in Ins 4004.01(a). Files containing the three most recent calendar years of data (January through December) shall be

submitted no later than 150 days after registration; year to date information and monthly or quarterly files must be provided no later than 180 days after registration.

B. Test Files Submission. At least 30 days prior to the initial submission of the files, each first time submitter carrier or third-party administrator shall submit conforming test files to the Department and the DHHS, or their designee. These files shall be used to determine compliance with the standards for data submission. The test file size shall correspond to the filing period established for that carrier or health care claims processor as specified in Ins 4006 (d).

C. Historical Files. Files containing the three most recent calendar years of data (January through December) shall be submitted no later than 150 days after registration; year to date information and monthly or quarterly files must be provided no later than 180 days after registration.

D. Carrier or Third-Party Administrator Initiated Changes in Data Submission, Process or Sources: Carriers and third-party administrators that change health plan identifiers or implement new data submission platforms through acquisitions, mergers, or reorganizations shall be subject to the requirements for first-time submitters. Carriers and third-party administrators filing under new health plan identifiers or through new production system shall provide additional documentation pursuant to instructions from the Department or its designee to ensure that NHCHIS maintains a continuous record of member enrollment and claims history before and after the changes.

V. File Specifications

A. General Data Submission Requirements and Standards

1. Each carrier and third-party administrator shall submit to the department or its designee a complete and accurate health care claims data set that conforms to these detailed instructions.

2. Each carrier or third-party administrator shall utilize the data transmission tool provided by the department or its designee to assign a unique identification code to each member and subscriber's record in every file, transform direct identifiers, encrypt the files and to securely transmit the file.

3. Each carrier and third-party administrator shall submit data that conforms to updated specifications no later than 180 days after the department's notification of such updates.

4. Each carrier and third-party administrator, who has technical deficiencies identified by the department or its designee in the data submitted, shall respond to the department within 10 days with a corrective action plan that is acceptable to the department.

B. Subscriber and Member Identification Data Elements:

1. Carriers and third-party administrators shall provide a unique identifier for each of their covered members and subscribers.

2. The unique member identifier shall be maintained for each member and subscriber for the entire period of coverage for that individual.

3. Subscriber and Member identifiers must be consistent across all files that contain information about the Subscriber or Member.

4. Subscriber and Member identifier fields must match across the Member Eligibility, Medical Claims, Pharmacy and Dental files, as well as Behavioral Health claims, as applicable.

5. The following table lists the Subscriber and Member identifiers that must be identical when reporting information about a Subscriber or a Member:

Table 1: Matching Requirements for Subscriber/Member Identifiers Across Files

Data Element Name*	Subscriber and Member Identifiers			
	Member Eligibility	**Medical Claims****	**Dental Claims**	**Pharmacy Claims**
Subscriber Social Security Number	ME008	MC007	DC007	PC007
Plan Specific Contract Number	ME009	MC008	DC008	PC008
Member Suffix or Sequence Number	ME010	MC009	DC009	PC009
Member Identification Code	ME011	MC010	DC010	PC010
Subscriber Last Name	ME101	MC101	DC101	PC101
Subscriber First Name	ME102	MC102	DC102	PC102
Subscriber Middle Initial	ME103	MC103	DC103	PC103
Member Last Name	ME104	MC104	DC104	PC104
Member First Name	ME105	MC105	DC105	PC105
Member Middle Initial	ME106	MC106	DC106	PC106
*The NHCHIS preprocessor hashes these data elements as part of the file encryption and transmission process.				
**Also pertains to Behavioral Health.				

6. The NH preprocessor application will hash all member and subscriber identification codes and names before data are transmitted to NHID's designee.

To ensure consistent hashing, subscriber and member identifiers should not be encrypted or hashed on the initial extract loaded into the preprocessor. If a third-party administrator does not collect the social security numbers for its members, the third-party administrator shall provide the social security number of the subscriber and assign a discrete two digit suffix for each member under the

subscriber's contract using the following criteria:

a) If the subscriber's social security number is not collected by the third-party administrator, the subscriber's certificate or contract number shall be used in its place (this data element will be de-identified by the NH preprocessor application).

b) The discrete two digit suffix shall also be used with the certificate or contract number (this data element will be de-identified by the NH preprocessor application).

c) The certificate or contract number with the two digit suffix shall be at least 11, but no more than 30 characters in length (this data element will be de-identified by the NH preprocessor application).

C. Included Records

1. Carriers and third-party administrators shall submit health care claims data for all members who are residents of New Hampshire and all members who receive their benefits under a policy or plan issued in New Hampshire. A policy that is issued in New Hampshire shall include any policy that provides coverage to the employees of a New Hampshire employer that has a business location in New Hampshire.

2. An out-of-state employer's branch location in New Hampshire shall be considered a New Hampshire employer, and the carriers and third party administrators shall submit a claims data set for all members who are employed at that branch location.

3. Carriers and third-party administrators shall submit health care claims data for New Hampshire state and municipal employees to NHCHIS.

4. Each carrier and third-party administrator shall submit all health care claims processed by any sub-contractor on its behalf. Each carrier and third-party administrator shall ensure that the sub-contractor is not submitting duplicate claims to the Department designee if the sub-contractor falls under the definition of a carrier, meets the requirements of this section, and must submit data as a separate entity.

5. When more than one entity is involved in the administration of a policy, the carrier shall be responsible for submitting the claims data on policies that it has written. The third party administrator shall be responsible for submitting claims data on self-insured plans that it administers.

6. Each carrier and third-party administrator shall submit all health care claims processed by any sub-contractor on its behalf. Each carrier and third-party administrator shall ensure that the sub-contractor is not submitting duplicate claims

to the Department designee if the sub-contractor falls under the definition of a carrier, meets the requirements of this section, and must submit data as a separate entity.

8. Records for medical, pharmacy and dental claims file submissions shall be reported at the visit, service, or prescription level.

9. Carriers and third-party administrators shall submit fully-processed claims service lines that have gone through an accounts payable run.

10. Claims where multiple parties have financial responsibility shall be included with all medical and pharmacy claims file submissions

11. Co-payment or co-insurance amounts shall be reported in two separate fields in the medical, pharmacy, and dental claims file submissions

12. Carriers and third party administrators shall include records for services provided under alternative payment arrangements with zero paid amounts.

13. Carriers and third-party administrators shall include denied claims in all claims file submissions

14. Medical, pharmacy, and dental claims files shall contain all of a claim's payment and adjustment activity during the reporting month regardless of the data of service on the claim.

15. Behavioral Health Claims: Carriers and third-party administrators shall submit all claims related to behavioral health, mental health and substance abuse treatment services in the medical claims file**.**

16. Pharmacy Claims: Carriers and third-party administrators shall submit all claims related to pharmacy services. Carriers and third-party administrators shall ensure that member and subscriber identifiers in the pharmacy file are consistent with member and subscriber identifiers in the medical and dental claims files and the member eligibility files.

17. Dental Health Claims: Carriers and third-party administrators shall submit all claims related to dental services. Carriers and third-party administrators shall ensure that member and subscriber identifiers in the dental file are consistent with member and subscriber identifiers in the medical and pharmacy claims files and the member eligibility files.

D. Observation Period for Record Selection:

1. Carriers and third-party administrators shall submit a member eligibility file that contains data for each member eligible for medical, dental or pharmacy benefits for one or more dates of coverage at any time during a reporting month as

well as any retrospective updates that correspond to previously submitted eligibility data. It should include benefits, attributes, and associated effective periods.

2. Carriers and third-party administrators shall include all claims adjudicated during the reporting month for all members in the member eligibility file for that month.

3. Carriers' and third-party administrators' data submissions shall contain appropriate claims run-out for members in all current or previously submitted files.

E. Code sources. Carriers and third-party administrators shall use the values in the data tables in Appendix A or the corresponding externally maintained code tables as listed in Section VIII.

F. Carrier-specific codes. Carriers and third-party administrators shall submit tables and descriptions for all non-conforming and plan-specific codes appearing in the submission. The Department and DHHS or its designee shall reject files with non-conforming and plan-specific codes if explanatory information is not provided in advance of the data submission.

G. Co-insurance/Co-payment. Report Co-insurance and co-payment amounts in two separate fields in the medical pharmacy, and dental claims file submission.

H. Coordination of Benefit Claims. Claims where multiple parties have financial responsibility shall be included with all medical and pharmacy claims file submissions.

I. Adjustment records. Report adjustment records with the appropriate positive or negative fields with the medical, pharmacy, and dental file submissions. Negative values shall contain the negative sign before the value. No sign shall appear before a positive value.

J. Version Number. When more than one version of a fully-processed claim service line is submitted, each version of a claim service line shall be enumerated sequentially with a higher version number (MC005A) so that the latest version of that service line is the record with the highest version number (MC005A) and the same claim number + line counter. Where a version number is not available, provide the former claim number in data element MC211. Similar requirements apply to the Pharmacy claim file.

K. Fully-Processed Claim Lines: Only fully-processed claim service lines that have gone through an accounts payable run and been booked to the health plan ledger or a denied claim that has been fully processed shall be included on medical, pharmacy, and dental claims data submissions.

L. Subsequent Incremental Claims. Subsequent incremental claims submissions shall include all reversal and adjustment/restated versions of previously submitted claim service lines and all new, fully-processed service lines associated with the claim, provided that they have paid dates in the reporting period:

a) Each version of a claim service line shall be enumerated sequentially with a higher line version number (MC005A); and

b) Reversal versions of a claim service line shall be indicated by a claim status code = '22' (Field MC038).

M. Capitated services claims. Include capitated service claims (sometimes known as encounter claims) for capitated services shall be reported with all medical and pharmacy file submissions.

N. Global Payment Arrangements. If a claim contains service lines that have been denied because their costs are covered on another line of the claim line, such as under a global payment arrangement, those denied line(s) shall be:

1. Included in the data submission; and

2. Clearly indicated by a claim status code = '04' (Field MC038).

O. Provider ID. The Provider ID (MP003) is the unique identifier for a single provider. The Provider ID should only occur once in the table. However, in the event the same provider delivered, and was reimbursed for, services rendered from two or more different physical locations, then the provider data file will contain two separate records for that same provider reflecting each of those physical locations. One record should be provided for each unique physical location.

P. File Submission Tools: Carriers and third-party administrators must use the File Submission "Preprocessor" provided by the DHHS and their designee. The Preprocessor hashes (de-identifies) member and subscriber information before the data leaves the carrier's and third-party administrator's system.

Q. Minimum Value Reporting Requirements: Carriers and third party administrators must report the Minimum Value for fully insured and self-insured products to support NHID Supplemental Reporting reviews. Non-situs carriers and third party administrators are not required to report this data element.

R. Premium Reporting Requirements: Carriers and third party administrators must report the funds associated with the administration of the employer's benefit plan.

VI. Data Submission Requirements

A. Header and Trailer Records

Each member eligibility file and each medical, pharmacy, and dental claims file submission must contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last.

B. File Submission Methods

All carriers and third-party administrators submitting APCD files will be provided with code in the form of a pre-processor, which generates the files in the required format and encrypts them prior to submission. The pre-processor code will be provided to all carriers and third-party administrators as a down load through a password protected portal.

Carriers and third-party administrators may submit APCD files using the following methods:

SFTP

Secure File Transport Protocol is the preferred method for submitting files. This method requires logging on to the appropriate FTP site and sending or receiving files using the SFTP client server. This protocol assumes that it is run over a secure channel (e.g., SSH) that the server has already authenticated the client, and that the identity of the client user is available to the protocol.

Web Upload

This method allows the sending and receiving of files and messages without the installation of additional software. This method requires internet access, a username, and password. It is not the preferred method due to limitations on the size of the files that can be received, but can be utilized if it is the only method available to the healthcare claims processor.

C. File Format

The member eligibility file, medical claims file, pharmacy claims file, dental claims file, and provider file should be submitted as separate ASCII files, with variable field lengths and pipe delimited, and should comply with the following standards:

1. Each record must be terminated with a carriage return and line feed (ASCII 13, ASCII 10).

2. All fields must be filled where applicable.

3. Text and date fields must be left blank when not applicable or if a value is not available.

4. “Blank” means do not supply any value at all between consecutive field delimiters or last field delimiter and line terminator. Numeric fields without a value must be filled with a single zero.

5. Always submit one record per row. No single line item of data may contain carriage return or line feed characters.

6. TEXT fields should never be padded with leading or trailing spaces or tabs.

7. NUMBER fields:

a) Should never be padded with leading zeroes.

b) The integer portion of numeric fields must not be padded with leading zeros. The decimal portion of numeric fields, if required, must be padded with trailing zeros up to the number of decimal places indicated.

c) Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all numeric fields.

8. DATE fields should be CCYYMMDD, unless otherwise indicated.

VII. Data Quality Requirements

A. Validation and Auditing

A validation process will be employed to ensure that the format and content of the submitted files are valid and complete. The validation process is primarily composed of three groups of audits: field level audits, quality audits, and post data consolidation reasonableness, longitudinal, and relational audits.

B. Field Level Audits

All transmitted files are first checked to determine if they are in the correct form and have been created using the provided pre-processor. Field level audits are then employed to evaluate field length and type, code values, and the percentage at which the fields are filled.

C. Quality Audits

Quality audits are employed to determine if the data submitted meet a pre-determined level of reasonableness (e.g., % of institutional claims vs. % of professional claims). Default thresholds (which can be rates or ranges) have been established for approximately 200 quality audits.

D. Reasonableness, Longitudinal, and Relational Audits

After the files are loaded into staging tables, additional audits are run on the consolidated data to identify any global issues that would not be evident during the field and quality level audit process. The reasonableness, longitudinal, and relational audits confirm whether the appropriate and correct amount of data was received for the corresponding membership volume. Examples of these audits are: frequency of individual field values; volume reconciliation; and cost/utilization reasonableness.

E. Threshold Establishment and Alteration

Default thresholds (or rates) will be applied to the field level audits for each element in the eligibility, claims files and provider file, and for each quality audit. The standard acceptable threshold for field length, field type, and data value audits is 100%. However, there are some fields where the acceptable thresholds for data value will be set at less than 100%. Individual field completeness thresholds are established for each

data element in the eligibility, medical, pharmacy, dental and provider files and will vary accordingly.

All of the pre-determined default thresholds can be individually adjusted if extenuating circumstances arise which may impact the data completeness or content. If a file is processed and rejected for failing to meet the field level and/or quality audit default thresholds, the healthcare claims processor can request an exemption to the default threshold through a standardized process. Exemptions or adjustments may be granted for data variances that cannot be corrected due to systematic issues.

F. Testing of Files

At least thirty days prior to the initial submission of the files or whenever the data element content of the files is subsequently altered, each healthcare claims processor must submit a data set for comparison to the same validation process used for actual submissions. Iterative rounds of testing may be necessary until the files conform to the submission requirements. A test file should contain data covering a period of one month.

G. Rejection of Files

Failure to conform to any of the submission requirements will result in the rejection and return of the applicable data file(s). All rejected and returned files should be resubmitted in the appropriate, corrected form within 10 days, or the healthcare claims processor may request an exemption to adjust the threshold for the failing field(s). Due to the large amount and complexity of the data processed, it is more efficient to resubmit an entire file rather than to correct data within the file.

VIII. External Code Sources

A. Countries

American National Standards Institute
http://webstore.ansi.org/SdoInfo.aspx?sdoid=39&source=iso_member_body

B. States, Zip Codes and Other Areas of the US

U.S. Postal Service
https://www.usps.com/

C. National Provider Identifiers

National Plan & Provider Enumeration System
https://nppes.cms.hhs.gov/NPPES/

D. Health Care Provider Taxonomy

National Uniform Claim Committee (NUCC)
http://www.nucc.org

E. International Classification of Diseases 9 & 10

American Medical Association
http://www.who.int/classifications/icd/en/

F. HCPCS, CPTs and Modifiers

American Medical Association
http://www.ama-assn.org/

G. Dental Procedure Codes and Identifiers

American Dental Association
http://www.ada.org/

H. National Drug Codes and Names

U.S. Food and Drug Administration
http://www.fda.gov/drugs/informationondrugs/ucm142438.htm

I. Standard Professional Billing Elements

Centers for Medicare and Medicaid Services (Rev. 10/26/12)
http://www.cms.gov/Regulations-and-fGuidance/Guidance/Manuals/downloads/clm104c26.pdf

J. Standard Facility Billing Elements

National Uniform Billing Committee (NUBC)
http://www.nubc.org/

K. DRGs, APCs and POA Codes

Centers for Medicare and Medicaid Services
http://www.cms.gov/

L. Claim Adjustment Reason Codes

Washington Publishing Company
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Appendix A-1 Member Eligibility Data Tables

Note: See Appendix C-1 for Member Eligibility File Mapping and Format Information

Table A-1(i) Member File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
HD001	Record Type	Text	2	HD
HD002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
HD003	National Plan ID	Text	30	CMS National Plan ID
HD004	Type of File	Text	2	ME Member Eligibility
HD005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
HD006	Period Ending Date	Date	8	End of paid period for claims or end of month covered for eligibility
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Table A-1(ii) Member File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
TR001	Record Type	Text	2	TR
TR002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
TR003	National Plan ID	Text	30	CMS National Plan ID
TR004	Type of File	Text	2	ME Member Eligibility
TR005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
TR006	Period Ending Date	Date	8	End of paid period for claims or beginning of month covered for eligibility
TR007	Extraction Date	Date	8	Date file was created
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file

	Table A-1(iii)Member File Detailed Specification				
Unique ID	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
1	ME001	Payer	Text	8	Payer submitting payments NHID Submitter Code
2	ME002	National Plan ID	Text	30	CMS National Plan ID
3	ME003	Insurance Type Code/Product	Text	2	See Appendix B-1: Insurance type/product code – Eligibility File
4	ME004	Start Year	Number	4 (0)	Year for which eligibility is reported in this submission. CCYY format
5	ME005	Start Month	Number	2 (0)	Month for which eligibility is reported in this submission. MM format. Leading zero is required for reporting January through September files
6	ME006	Insured Group or Policy Number	Text	50	Group or policy number (not the number that uniquely identifies the subscriber)
7	ME007	Coverage Level Code	Text	3	Benefit Coverage Level
					CHD Children Only
					DEP Dependents Only
					ECH Employee and Children
					EMP Employee Only
					ESP Employee and Spouse
					FAM Family
					IND Individual
					SPC Spouse and Children
					SPO Spouse Only
8	ME008	Subscriber Social Security Number	Text	9	Subscriber's social security number. Do not include dashes. Leave blank if not available.
9	ME009	Plan Specific Contract Number	Text	50	Plan assigned contract number. Leave blank if Plan Specific Contract Number is subscriber's social security number. If this is a Medicaid member, provide Medicaid ID

	Table A-1(iii)Member File Detailed Specification				
Unique ID	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
10	ME010	Member Suffix or Sequence Number	Text	20	Uniquely identifies the member within the contract
11	ME011	Member Social Security Number	Text	9	Member's social security number. Do not include dashes. Leave blank if not available.
12	ME012	Individual Relationship Code	Text	2	See Appendix B-2: Relationship Codes
13	ME013	Member Gender	Text	1	M Male
					F Female
					U Unknown
					O Other
14	ME014	Member Date of Birth	Date	8	Date of birth of member
15	ME015	Member City Name	Text	30	City name of member
16	ME016	Member State or Province	Text	2	As defined by the US Postal Service
17	ME017	Member ZIP Code	Text	9	ZIP Code of member – may include non- US codes. Do not include dash.
18	ME018	Medical Coverage	Text	1	Y Yes, member has medical coverage in the period defined with this payer
					N No, member does not have medical coverage in the period with this payer
19	ME019	Prescription Drug Coverage	Text	1	Y Yes, member has prescription drug coverage in the period defined with this payer
					N No, member does not have prescription drug coverage in the period defined with this payer
20	ME020	Dental Coverage	Text	1	Y Yes, member does not have dental drug coverage in the

	Table A-1(iii)Member File Detailed Specification				
Unique ID	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
					period defined with this payer
					N No, member does not have dental drug coverage in the period defined with this payer
21	ME021	Race 1	Text	6	See Appendix B-3: Race1/Race 2
22	ME022	Race 2	Text	6	See Appendix B-3: Race1/Race 2
23	ME023	Placeholder			
24	ME024	Hispanic Indicator	Text	1	Y Yes, member is Hispanic/Latino/Spanish
					N No, member is not Hispanic/Latino/Spanish
					U Unknown
25	ME025	Ethnicity 1	Text	6	See Appendix B-4: Ethnicity 1/ Ethnicity 2
26	ME026	Ethnicity 2	Text	6	See Appendix B-4: Ethnicity 1/ Ethnicity 2
27	ME027	Place holder		20	
28	ME028	Primary Insurance Indicator	Text	1	Y Yes, this is the member's primary insurance
					N No, this is not the member's primary insurance
29	ME029	Coverage Type	Text	3	ASW Self-funded plans that are administered by a third party administrator, where the employer has purchased stop-loss, or group excess insurance coverage
					ASO Self-funded plans that are administered by a third party administrator, where the employer has not purchased stop-loss, or group excess insurance coverage
					STN Short-term non-renewable health insurance, as defined pursuant to RSA 415:5 III
					MCD Insurance sold to protect the health of Medicaid eligible individuals, generally purchased by state governments, shall not be considered major medical expense. Carriers and third-party administrators shall

	Table A-1(iii)Member File Detailed Specification				
Unique ID	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
					report such business as other than major medical expense coverage and use the Medicaid related insurance code
					MCR Medicare
					UND Plans underwritten by the carrier
					OTH Any other plan. Carriers and third-party administrators using this code shall obtain prior approval from the N.H. Insurance Department
30	ME030	Market Category	Text	4	IND Policies sold and issued directly to individuals, other than those sold on a franchise basis, as defined pursuant to RSA 415:19, or as group conversion Policies as defined pursuant to RSA 415:18 VII (a)
					FCH Policies sold and issued directly to individuals on a franchise basis as defined pursuant to RSA 415:19
					GCV Policies sold and issued directly to individuals as group conversion Policies as required pursuant to RSA 415:18 VII (a)
					GS1 Policies sold and issued directly to employers having exactly one employee
					GS2 Policies sold and issued directly to employers having between 2 and 9 employees
					GS3 Policies sold and issued directly to employers having between 10 and 25 employees
					GS4 Policies sold and issued directly to employers having between 26 and 50 employees
					GLG1 Policies sold and issued directly to employers having between 51 and 99 employees
					GLG2 Policies sold and issued directly to employers having 100 or more employees
					GSA Policies sold and issued directly to small employers

	Table A-1(iii)Member File Detailed Specification				
Unique ID	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
					through a qualified association trust
					OTH Policies sold to other types of entities. Carriers and third-party administrators using this market code shall obtain prior approval from the NH Insurance Department
					BLC Policies sold and issued as blanket health insurance Policies to a common carrier
					BLE Policies sold and issued as blanket health insurance Policies to an employer
					BLV Policies sold and issued as blanket health insurance Policies to a volunteer fire department, first aid, or other such volunteer group
					BLS Policies sold and issued as blanket health insurance Policies to a sports team or a camp
					BLT Policies sold and issued as blanket health insurance Policies to a travel agency, or other organization that provides travel-related services
					BLU Policies sold and issued as blanket health insurance Policies to a university or college
					SLG Policies sold and issued as student major medical expense large group coverage to enrolled students at an accredited college, university, or other educational institution
					STS Policies sold and issued as group short term student health insurance
					SMG Policies sold and issued as student major medical group health insurance
					SNM Policies sold and issued as student group health insurance that is not major medical coverage
					SIM Policies sold and issued as student individual major

	Table A-1(iii)Member File Detailed Specification				
Unique ID	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
					medical health insurance
					SIN Policies sold and issued as student individual health insurance that is not major medical coverage
31	ME031	Special Coverage	Text	3	0 No, not applicable
					1 Yes, member is enrolled in HealthFirst plan
32	ME032	Group Name	Text	128	Name of the group which the member is covered by. If the member is part of a group of one or non-group then leave field blank
33	ME101	Subscriber Last Name	Text	60	
34	ME102	Subscriber First Name	Text	35	
35	ME103	Subscriber Middle Initial	Text	1	
36	ME104	Member Last Name	Text	60	
37	ME105	Member First Name	Text	35	
38	ME106	Member Middle Initial	Text	1	
39	ME201	Member Street Address	Text	50	Street address of member.
40	ME203	Member's Assigned PCP	Text	20	National Provider ID of the member's Primary Care Physician as designated by healthcare claims processor.
41	ME204	HIOS Plan ID	Text	16	The 16 character HIOS Plan ID (Standard component). Including a five digit issuer ID, two character state ID, three digit product number, four digit standard component number and two digit variant component ID.

	Table A-1(iii)Member File Detailed Specification				
Unique ID	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
					This field may not be available for all market segments;
42	ME205	Plan Effective Date	Date	8	For the plan reported in ME204, report the date eligibility started for this member under this plan type. The purpose of this data element is to maintain an eligibility span for each member.
43	ME205	Minimum Value	Number	3 (0)	For the plan reported in ME204, report Minimum Value as defined in New Hampshire Insurance Department Bulletin INS No. 14-005-AB. Applies only to carriers and third party administrators with NH situs; non-NH situs data filers are not required to file. This is reported as a percentage.
44	ME206	Exchange Indicator	Text	1	The plan reported in ME204 is available on the Exchange Marketplace in the month and year reflected in ME004 and ME005
					Y Yes
					N No
					U Unknown
45	ME207	High deductible health plan	Text	1	The plan reported in ME204 meets the IRS definition of a HDHP
					Y Yes
					N No
					U Unknown
46	ME208	Active enrollment	Text	1	The plan reported in ME204 is open for enrollment in the year and month reflected in ME004 and ME005
					Y Yes
					N No
					U Unknown
47	ME210	New Coverage	Text	1	The plan reported in ME204 is being offered for the first

	Table A-1(iii)Member File Detailed Specification				
Unique ID	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
					time in the reporting year reflected in ME004
					Y Yes
					N No
					U Unknown
48	ME211	Monthly Premium or Premium Equivalent	Number	10 (2)	Premium or Premium Equivalent is the dollar amount defined as "the funds collected from contracted accounts to provide for all claims and expenses associated with the administration of the employer's benefit plan". Report 0 only when the subscriber is contractually free of this obligation. Required only for carriers and third party administrators with NH situs.
49	ME899	Record Type	Text	2	ME

Appendix A-2 Medical Claims Data Tables

Note: See Appendix C-2 for Medical Eligibility File Mapping and Format Information

Table A-2(i) Medical Claims File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
HD001	Record Type	Text	2	HD
HD002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
HD003	National Plan ID	Text	30	CMS National Plan ID
HD004	Type of File	Text	2	MC Medical Claims
HD005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
HD006	Period Ending Date	Date	8	End of paid period for claims or end of month covered for eligibility
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Table A-2(ii) Medical Claims File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places**	**Description/Codes/Sources**
TR001	Record Type	Text	2	TR
TR002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
TR003	National Plan ID	Text	30	CMS National Plan ID
TR004	Type of File	Text	2	MC Medical Claims
TR005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
TR006	Period Ending Date	Date	8	End of paid period for claims or beginning of month covered for eligibility
TR007	Extraction Date	Date	8	Date file was created
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MC001	Payer	Text	8	Payer submitting payments NHID Submitter Code
MC002	National Plan ID	Text	30	CMS National Plan ID
MC003	Insurance Type/Product Code	Text	2	See Appendix B-5: Insurance Type/Product Code – Claims Files
MC004	Payer Claim Control Number	Text	35	Must apply to the entire claim and be unique within the payer's system
MC005	Line Counter	Text	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim
MC005A	Version Number	Number	4 (0)	Version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line
MC006	Insured Group or Policy Number	Text	50	Group or policy number (not the number that uniquely identifies the subscriber)
MC007	Subscriber Social Security Number	Text	9	Subscriber's social security number. Do not include dashes. Leave blank if not available.
MC008	Plan Specific Contract Number	Text	50	Plan assigned contract number. Leave blank if Plan Specific Contract Number is subscriber's social security number. If this is a Medicaid claim, provide Medicaid ID.
MC009	Member Suffix or Sequence Number	Text	20	Uniquely identifies the member within the contract
MC010	Member Social Security Number	Text	9	Member's social security number. Do not include dashes. Leave blank if not available.
MC011	Individual Relationship Code	Text	2	See Appendix B-2: Relationship Codes
MC012	Member Gender	Text	1	M Male
				F Female

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				U Unknown
MC013	Member Date of Birth	Date	8	Date of birth of member
MC014	Member City Name	Text	30	City name of member
MC015	Member State or Province	Text	2	As defined by the US Postal Service
MC016	Member ZIP Code	Text	9	ZIP Code of member – may include non- US codes. Do not include dash.
MC017	Paid Date (AP Date)	Date	8	
MC018	Admission Date	Date	8	Required for all inpatient claims.
MC019	Admission Hour	Text	2 (0)	Required for all inpatient claims. Time is expressed in military time – HH
MC020	Admission Type	Text	1	Required for all inpatient claims (SOURCE: National Uniform Billing Data Element Specifications): 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma Center 9 = Information not available
MC021	Admission Source	Text	1	See Appendix B-9 Point of Origin Codes
MC022	Discharge Hour	Text	2 (0)	Required for all inpatient claims. Time is expressed in military time – HH
MC023	Discharge Status	Text	2	See appendix B-6: Discharge Status
MC024	Service Provider Number	Text	30	Payer assigned servicing provider number by the payer for internal identification purposes
MC025	Service Provider	Text	10	Federal taxpayer's identification number

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
	Tax ID Number			
MC026	National Service Provider ID	Text	20	Provider NPI
MC027	Service Provider Entity Type Qualifier	Text	1	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as "Person".
				1 Person
				2 Non-Person Entity
MC028	Service Provider First Name	Text	35	Individual first name. Leave blank if provider is a facility or organization
MC029	Service Provider Middle Name	Text	25	Individual middle name or initial. Leave blank if provider is a facility or organization
MC030	Servicing Provider Last Name or Organization Name	Text	60	Report the name of the organization or last name of the individual provider. MC027 determines if this is an organization or Individual Name reported here.
MC031	Service Provider Suffix	Text	10	Suffix to individual name. Leave blank if provider is a facility or organization. Should be used to capture the generation of the individual clinician (e.g., Jr. Sr., III), if applicable, rather than the clinician's degree [e.g., 'MD', 'LICSW'].
MC032	Service Provider Specialty	Text	10	National Uniform Claims Committee (NUCC) standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of nurses, assistants and laboratory technicians, where applicable, as well as Physicians, Medical Groups, Facilities, etc.
MC033	Service Provider City Name	Text	30	City name of rendering provider - practice location
MC034	Service Provider State	Text	2	As defined by the US Postal Service
MC035	Service Provider ZIP Code	Text	9	ZIP Code of provider - may include non-US codes.

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MC036	Type of Bill – Institutional	Text	3	For facility claims only, such as those submitted using UB04 forms) Type of Facility - First Digit
				1 Hospital
				2 Skilled Nursing
				3 Home Health
				4 Christian Science Hospital
				5 Christian Science Extended Care
				6 Intermediate Care
				7 Clinic
				8 Special Facility
				Bill Classification - Second Digit if First Digit = 1-6
				1 Inpatient (Including Medicare Part A)
				2 Inpatient (Medicare Part B Only)
				3 Outpatient
				4 Other (for hospital referenced diagnostic services
				or home health not under a plan of treatment)
				5 Nursing Facility Level I
				6 Nursing Facility Level II
				7 Intermediate Care - Level III Nursing Facility
				8 Swing Beds
				Bill Classification - Second Digit if First Digit = 7
				1 Rural Health
				2 Hospital Based or Independent Renal Dialysis Center
				3 Free Standing Outpatient Rehabilitation Facility (ORF)
				5 Comprehensive Outpatient Rehabilitation Facility (ORF)

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				6 Community Mental Health Center
				9 Other
				Bill Classification – Second Digit if First Digit = 8
				1 Hospice (Non Hospital Based
				2 Hospice (Hospital-Based)
				3 Ambulatory Surgery Center
				4 Free Standing Birthing Center
				9 Other
				Frequency – Third Digit
				0 Non-Payment/Zero
				1 Admit Through Discharge
				2 Interim – First Claim
				3 Interim - Continuing Claims
				4 – Interim – Last Claim
				5 – Late Charge Only
				7 – Replacement of Prior Claim
				8 – Void/Cancel of a Prior Claim
				9 – Final Claim for a Home Health PPS Episode
MC037	Place of Service – Professional*)*	Text	2	For professional claims only, such as those submitted using CMS1500 forms See appendix B-7: Place of Service – Professional
MC038	Service Line Status	Text	2	Describes the payment status of the specific service line record
				01 Processed as primary
				02 Processed as secondary
				03 Processed as tertiary
				04 Denied
				19 Processed as primary, forwarded to additional payer(s)
				20 Processed as secondary, forwarded to additional payer(s)

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				21 Processed as tertiary, forwarded to additional payer(s)
				22 Reversal of previous payment
MC039	Admitting Diagnosis	Text	7	ICD-CM Diagnosis Codes. Required on all inpatient admission claims and encounters. Do not include decimals.
MC040	E-Code	Text	7	ICD-CM Diagnosis Codes. Describes an injury, poisoning or adverse effect ICD-CM.
MC041	Principal Diagnosis	Text	7	ICD-CM Diagnosis Codes. Principal Diagnosis should be the principal diagnosis given on the claim header. Do not include decimals.
MC042	Other Diagnosis -1	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC043	Other Diagnosis -2	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC044	Other Diagnosis -3	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC045	Other Diagnosis -4	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC046	Other Diagnosis -5	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC047	Other Diagnosis -6	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC048	Other Diagnosis -7	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC049	Other Diagnosis -8	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC050	Other Diagnosis -9	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC051	Other Diagnosis -10	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC052	Other Diagnosis -	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
	11			
MC053	Other Diagnosis - 12	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC054	Revenue Code	Text	4	National Uniform Billing Committee Codes. Code using leading zeroes, left-justified, and four digits.
MC055	Procedure Code	Text	5	Health Care Common Procedural Coding System (HCPCS). This includes the CPT codes of the American Medical Association
MC056	Procedure Modifier – 1	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC057	Procedure Modifier – 2	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC058	ICD-9-CM Procedure Code	Text	4	Primary ICD-9-CM code given on the claim header.
MC059	Date of Service – From	Date	8	First date of service for this service line.
MC060	Date of Service – Thru	Date	8	Last date of service for this service line
MC061	Quantity	Number	11 (0)	Count of services performed.
MC062	Charge Amount	Number	10 (2)	
MC063	Paid Amount	Number	10 (2)	Includes any withhold amounts.
MC064	Fee for Service Equivalent	Number	10 (2)	For capitated services, the fee for service equivalent amount.
MC065	Copay Amount	Number	10 (2)	The preset, fixed dollar amount for which the individual is responsible.
MC066	Coinsurance Amount	Number	10 (2)	Coinsurance , dollar amount
MC067	Deductible Amount	Number	10 (2)	
MC068	Patient	Text	20	

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
	Account/Control Number			
MC069	Discharge Date	Date	8	Required for all inpatient(s)
MC070	Service Provider Country Name	Text	30	
MC071	DRG	Text	3	Carriers and third-party administrators shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the All Payer DRG system is available, then that system shall be used. If the All Payer DRG system is used, the carrier shall format the DRG and the complexity level within the same field with an "A" prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX)
MC072	DRG Version	Text	2	This element is the version number of the grouper used.
MC073	APC	Text	4	Carriers and third-party administrators shall code using CMS methodology. Precedence shall be given to APCs transmitted from the health care provider
MC074	APC Version	Text	2	This element is the version number of the grouper used
MC075	Drug Code	Text	11	NDC Code Used only when a medication is paid for as part of a medical claim.
MC076	Billing Provider Number	Text	30	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes and does not routinely change
MC077	National Billing Provider Number ID	Text	30	This is the NPI for the billing provider
MC078	Billing Provider Organization or Last Name	Text	60	

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MC101	Subscriber Last Name	Text	60	
MC102	Subscriber First Name	Text	35	
MC103	Subscriber Middle Initial	Text	1	
MC104	Member Last Name	Text	60	
MC105	Member First Name	Text	35	
MC106	Member Middle Initial	Text	1	
MC200	ICD Indicator	Text	1	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10.
				0 ICD-9
				1 ICD-10
MC202	Other ICD-CM Procedure Code - 2	Text	7	ICD Secondary Procedure Code
MC203	Other ICD-CM Procedure Code - 3	Text	7	ICD Secondary Procedure Code
MC204	Other ICD-CM Procedure Code - 4	Text	7	ICD Secondary Procedure Code
MC205	Other ICD-CM Procedure Code - 5	Text	7	ICD Secondary Procedure Code
MC206	Other ICD-CM Procedure Code - 6	Text	7	ICD Secondary Procedure Code
MC207	Carrier Associated with Claim	Text	8	For each claim, the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved-out services are

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				submitted by the carrier with unified member IDs in all files.
MC208	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	Text	128	For each claim, the carrier specific contract number or subscriber/member social security number when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
MC209	Practitioner Group Practice	Text	60	Name of group practice to which a practitioner is affiliated if different from MC078
MC210	COB/TPL Amount	Number	10 (2)	Dollar amount paid from a prior payer (e.g. auto claim, workers comp, dual medical coverage). Report 0 if there is no COB/TPL amount.
MC211	Cross Reference Claims ID	Text	35	The original Payer Claim Control Number (MC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (MC005A) is not used.
MC212	Allowed Amount	Number	10 (2)	Report the maximum dollar amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider.
MC215	Service Line Type	Text	1	Report the code that defines the claim line status in terms of adjudication
				O Original
				V Void
				R Replacement
				B Back Out
				A Amendment
MC216	Payment Arrangement Type	Text	1	Defines the contracted payment methodology for this claim line
				1 Capitation
				2 Fee for service
				3 Percent of charges

Table A-2 (iii) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				4 DRG
				5 Pay for Performance
				6 Global Payment
				7 Other
				8 Bundled payment
MC217	Pay for Performance Flag	Text	1	Does this provider have pay-for-performance bonuses or year-end withhold returns based on performance for at least one service performed by this provider within the month? Required when MP003 = 1, 2, or 3
				Y Yes
				N No
MC218	Denied Claim Indicator	Text	1	1 Fully Paid – the entire claim was paid at the allowed amount
				2 Partially denied – some of the claims lines were paid at the allowed amount
				3 Encounter claim – this claim records a service provided that is paid under a non FFS payment arrangement such as capitation
				4 No payment – no payment made for reasons other than non FSS payment arrangement
MC219	Denial Reason	Text	15	Denial reason code. Required when denied claim indicator = 2 or 4 http://www.wpc-edi.com/reference/
MC220	Procedure Modifier – 3	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC221	Procedure Modifier – 4		2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC899	Record Type	Text	2	MC

Appendix A-3 Pharmacy Claims Data Tables

Note: See Appendix C-3 for Pharmacy Claims File Mapping and Format Information

Table A-3(i) Pharmacy Claims File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places**	**Description/Codes/Sources**
HD001	Record Type	Text	2	HD
HD002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
HD003	National Plan ID	Text	30	CMS National Plan ID
HD004	Type of File	Text	2	PC Pharmacy Claims
HD005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
HD006	Period Ending Date	Date	8	End of paid period for claims or end of month covered for eligibility
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Table A-3(ii) Pharmacy Claims File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
TR001	Record Type	Text	2	TR
TR002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
TR003	National Plan ID	Text	30	CMS National Plan ID
TR004	Type of File	Text	2	PC Pharmacy Claims
TR005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
TR006	Period Ending Date	Date	8	End of paid period for claims or beginning of month covered for eligibility
TR007	Extraction Date	Date	8	Date file was created
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file

Table A-3(iii) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
PC001	Payer	Text	8	Payer submitting payments NHID Submitter Code
PC002	Plan ID	Text	30	CMS National Plan ID
PC003	Insurance Type/Product Code	Text	2	See Appendix B-5: Insurance Type/Product Code – Claims Files
PC004	Payer Claim Control Number	Text	35	Must apply to the entire claim and be unique within the payer's system
PC005	Line Counter	Text	4	Line number for this service The line counter begins with 1 and is incremented by 1 for each additional service line of a claim
PC006	Insured Group Number	Text	50	Group or policy number (not the number that uniquely identifies the subscriber)
PC007	Subscriber Social Security Number	Text	9	Subscriber's social security number. Do not include dashes. Leave blank if not available.
PC008	Plan Specific Contract Number	Text	50	Plan assigned contract number. Leave blank if Plan Specific Contract Number is subscriber's social security number. If this is a Medicaid claim, provide Medicaid ID.
PC009	Member Suffix or Sequence Number	Text	20	Uniquely identifies the member within the contract
PC010	Member Social Security Number	Text	9	Member's social security number. Do not include dashes. Leave blank if not available.
PC011	Individual Relationship Code	Text	2	See Appendix B-2: Relationship Codes insured
PC012	Member Gender	Text	1	M Male
				F Female
				U Unknown
PC013	Member Date of Birth	Date	8	

Table A-3(iii) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
PC014	Member City Name of Residence	Text	30	City name of member
PC015	Member State	Text	2	As defined by the US Postal Service
PC016	Member ZIP Code	Text	9	ZIP Code of member – may include non- US codes. Do not include dash.
PC017	Paid Date (AP Date)	Date	8	Paid date or the Pharmacy Benefits Manager's billing date
PC018	Pharmacy Number	Text	30	Payer assigned pharmacy number. AHFS number is acceptable
PC019	Pharmacy Tax ID Number	Text	10	Federal taxpayer's identification number *(Please provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.)*
PC020	Pharmacy Name	Text	30	Name of pharmacy
PC021	National Pharmacy ID Number	Text	20	Required if National Provider ID is mandated for use under HIPAA
PC022	Pharmacy Location City	Text	30	City name of pharmacy - preferably pharmacy location
PC023	Pharmacy Location State	Text	2	As defined by the US Postal Service
PC024	Pharmacy ZIP Code	Text	9	ZIP Code of pharmacy - may include non- US codes. Do not include dash
PC024A	Pharmacy Country Name	Text	30	Code US
PC025	Service Line Status	Text	2	See Appendix B-8: Service Line Status
PC026	Drug Code	Text	11	NDC Code with leading zeros and no hyphens.
PC027	Drug Name	Text	80	Text name of drug
PC028	New Prescription	Number	2 (0)	00 New prescription. 01-99 Number of refill(s)
PC029	Generic Drug Indicator	Text	2	01 No, branded drug
				02 Yes, generic drug
PC030	Dispense as	Text	1	0 Not dispensed as written

Table A-3(iii) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
	Written Code			
				1 Physician dispense as written
				2 Member dispense as written
				3 Pharmacy dispense as written
				4 No generic available
				5 Brand dispensed as generic
				6 Override
				7 Substitution not allowed - brand drug mandated by law
				8 Substitution allowed - generic drug not available in marketplace
				9 Other
PC031	Compound Drug Indicator	Text	1	N Non-compound drug
				Y Compound drug
				U Non-specified drug compound
PC032	Date Prescription Filled	Date	8	
PC033	Quantity Dispensed	Number	10	Number of metric units of medication dispensed
PC034	Days' Supply	Number	3	Estimated number of days the prescription will last
PC035	Charge Amount	Number	10 (2)	Charge amount in dollars
PC036	Paid Amount	Number	10 (2)	Includes all health plan payments and excludes all member payments. Do not code decimal point
PC037	Ingredient Cost/List Price	Number	10 (2)	Cost of the drug dispensed. Do not code decimal point
PC038	Postage Amount Claimed	Number	10 (2)	Postage amount in dollars
PC039	Dispensing Fee	Number	10 (2)	Dispensing fess in dollars
PC040	Copay Amount	Number	10 (2)	The preset, fixed dollar amount for which the individual is responsible.
PC041	Coinsurance	Number	10 (2)	Coinsurance amount in dollars

Table A-3(iii) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
	Amount			
PC042	Deductible Amount	Integer	10 (2)	Deductible amount in dollars
PC043	Place holder			
PC044	Prescribing Physician First Name	Text	35	Physician first name
PC045	Prescribing Physician Middle Name	Text	25	Physician middle name
PC046	Prescribing Physician Last Name	Text	60	Physician last name
PC047	Prescribing Physician Number	Text	30	Carriers and third-party administrators shall code using the payer assigned provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change.
PC101	Subscriber Last Name	Text	60	
PC102	Subscriber First Name	Text	35	
PC103	Subscriber Middle Initial	Text	1	
PC104	Member Last Name	Text	60	
PC105	Member First Name	Text	35	
PC106	Member Middle Initial	Text	1	
PC203	Carrier Associated	Text	8	For each claim, the NAIC code of the carrier when a PBM processes

Table A-3(iii) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
	with Claim			claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
PC204	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	Text	128	For each claim, the carrier specific contract number or subscriber/member social security number when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
PC211	Cross Reference Claims ID	Text	35	The original Payer Claim Control Number (PC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim.
PC212	Allowed amount	Number	10 (2)	Report the maximum amount contractually allowed for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider.
PC213	HIOS Plan ID	Text	16	The 16 character HIOS Plan ID (Standard component). Including a five digit issuer ID, two character state ID, three digit product number, four digit standard component number and two digit variant component ID. This field may not be available for all market segments; Leave blank if not available
PC214	Claim Line Type	Text	1	Report the code that defines the claim line status in terms of adjudication
				O Original
				V Void
				R Replacement
				B Back Out
				A Amendment
PC215	Denied Claim Indicator	Text	1	1 Fully Paid – the entire claim was paid at the allowed amount
				2 Partially denied – some of the claims lines were paid at the allowed

Table A-3(iii) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				amount
				3 Encounter claim – this claim records a service provided that is paid under a non FFS payment arrangement such as capitation
				4 No payment – no payment made for reasons other than non FSS payment arrangement
PC219	Denial Reason	Text	15	Denial reason code. Required when denied claim indicator = 2 or 4 http://www.wpc-edi.com/reference/codelists/healthcare/health-care-services-decision-reason-codes/
PC899	Record Type	Text	2	PC

Appendix A-4 Dental Claims Data Table

Note: See Appendix C-4 for Dental Claims File Mapping and Format Information

Table A-4(i) Dental Claims Header File Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
HD001	Record Type	Text	2	HD
HD002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
HD003	National Plan ID	Text	30	CMS National Plan ID
HD004	Type of File	Text	2	DC Dental Claims
HD005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
HD006	Period Ending Date	Date	8	End of paid period for claims or end of month covered for eligibility
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Table A-4(ii) Dental Claims Trailer File Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
TR001	Record Type	Text	2	TR
TR002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
TR003	National Plan ID	Text	30	CMS National Plan ID
TR004	Type of File	Text	2	DC Dental Claims
TR005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
TR006	Period Ending Date	Date	8	End of paid period for claims or beginning of month covered for eligibility
TR007	Extraction Date	Date	8	Date file was created
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file

Table A-4(i) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
DC001	Payer	Text	8	Payer submitting payments
DC002	National Plan ID	Text	30	CMS National Plan ID
DC003	Insurance Type/Product Code	Text	2	See Appendix B-1: Insurance type/product code – Eligibility File
DC004	Payer Claim Control Number	Text	35	Must apply to entire claim and be unique within payer's system
DC005	Line Counter	Text	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim
DC006	Insured Group or Policy Number	Text	50	Group or policy number (not the number that uniquely identifies the subscriber)
DC007	Subscriber Social Security Number	Text	9	Subscriber's social security number. Do not include dashes. Leave blank if not available.
DC008	Plan Specific Contract Number	Text	50	Plan assigned contract number. Leave blank if Plan Specific Contract Number is subscriber's social security number. If this is a Medicaid claim, provide Medicaid ID.
DC009	Member Suffix or Sequence Number	Text	20	Uniquely identifies the member within the contract
DC010	Member Social Security Number	Text	9	Member's social security number. Do not include dashes. Leave blank if not available.
DC011	Individual Relationship Code	Text	2	See Appendix B-2: Relationship Codes
DC012	Member Gender	Text	1	M Male
				F Female
				U Unknown
				O Other
DC013	Member Date of	Date	8	

Table A-4(i) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
	Birth			
DC014	Member City Name	Text	30	City name of member
DC015	Member State or Province	Text	2	As defined by the U.S. Postal Service
DC016	Member ZIP Code	Text	9	ZIP Code of member – may include non- US codes. Do not include dash.
DC017	Paid Date/AP Date	Date	8	
DC018	Service Provider Number	Text	30	Payer assigned provider number
DC019	Service Provider Tax ID Number	Text	10	Federal Taxpayer's identification number
DC020	National Service Provider ID	Text	20	Required if National Provider ID is mandated for use under HIPAA
DC021	Service Provider Entity Type Qualifier	Text	1	1 Person
				2 Non-Person Entity
DC022	Service Provider First Name	Text	35	Individual first name. Leave blank if provider is a facility or organization
DC023	Service Provider Middle Name	Text	25	Individual middle name or initial. Leave blank if provider is a facility or organization
DC024	Servicing Provider Last Name or Organization Name	Text	60	Report the name of the organization or last name of the individual provider. DC021 determines if this is an Organization or Individual Name reported here.
DC025	Service Provider Suffix	Text	10	Suffix to individual name. Leave blank if provider is a facility or organization
DC026	Service Provider Specialty	Text	10	National Uniform Claims Committee (NUCC) standard code that defines this provider for this line of service. Dictionary for specialty

Table A-4(i) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				code values must be supplied during testing.
DC027	Service Provider City Name	Text	30	City name of provider - practice location
DC028	Service Provider State or Province	Text	2	As defined by the U.S. Postal Service
DC029	Service Provider ZIP Code	Text	9	ZIP Code of provider - may include non-US codes.
DC030	Place of Service - Professional	Text	2	See appendix B-7: Place of Service – Professional
DC031	Claim Status	Integer	2	See Appendix B-8: Claim Status
DC032	CDT Code	Text	5	Common Dental Terminology code
DC033	Procedure Modifier - 1	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
DC034	Procedure Modifier - 2	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
DC035	Date of Service - From	Date	8	First date of service for this service line.
DC036	Date of Service - Thru	Date	8	Last date of service for this service line.
DC037	Charge Amount	Number	10 (2)	
DC038	Paid Amount	Number	10 (2)	
DC039	Copay Amount	Number	10 (2)	The present, fixed dollar amount for which the individual is responsible.
DC040	Coinsurance Amount	Number	10 (2)	The dollar amount an individual is responsible for - not the percentage.
DC041	Deductible Amount	Number	10 (2)	

Table A-4(i) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
DC042	Billing Provider Number	Text	30	Carriers, third-party administrators, and dental claims processors shall code using the payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change
DC043	National Billing Provider Number ID	Text	30	This is the NPI for the billing provider
DC044	Billing Provider Last Name	Text	60	Full name of provider billing organization or last name of individual billing provider.
DC101	Subscriber Last Name	Text	60	
DC102	Subscriber First Name	Text	35	
DC103	Subscriber Middle Initial	Text	1	
DC104	Member Last Name	Text	60	
DC105	Member First Name	Text	35	
DC106	Member Middle Initial	Text	1	
DC201	Carrier Associated with Claim	Text	8	For each claim, the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all dental claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
DC202	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	Text	128	For each claim, the carrier specific contract number or subscriber/member social security number when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.

Table A-4(i) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
DC203	Practitioner Group Practice	Text	60	Name of group practice to which a practitioner is affiliated if different from DC044.
DC204	Tooth Number/Letter	Text	20	Report the tooth identifier(s) when DC032 is within the given range. Required when DC032 = D2000 thru D2999
DC205	Dental Quadrant	Text	2	Standard quadrant identifier from the External Code Source here. Provides further detail on procedure(s)
DC206	Tooth Surface	Text	20	Tooth surface(s) that this service relates to. Provides further detail on procedure
DC207	Claim Version	Text	4	Version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.
DC208	Diagnosis Code	Text	7	ICD CM Diagnosis Code when applicable
DC209	ICD Indicator	Text	1	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10.
				0 ICD-9
				1 ICD-10
DC211	Cross Reference Claims ID	Text	35	The original Payer Claim Control Number (DC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim.
DC212	Allowed amount	Number	10 (0)	Report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider. Report 0 when the claim line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070

Table A-4(i) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
DC213	HIOS Plan ID	Text	16	The 16 character HIOS Plan ID (Standard component). Including a five digit issuer ID, two character state ID, three digit product number, four digit standard component number and two digit variant component ID. This field may not be available for all market segments; Leave blank where not available
DC215	Claim Line Type	Text	1	Report the code that defines the claim line status in terms of adjudication
				O Original
				V Void
				R Replacement
				B Back Out
				A Amendment
DC218	Denied Claim Indicator	Text	1	1 Fully Paid – the entire claim was paid at the allowed amount
				2 Partially denied – some of the claims lines were paid at the allowed amount
				3 Encounter claim – this claim records a service provided that is paid under a non FFS payment arrangement such as capitation
				4 No payment – no payment made for reasons other than non FSS payment arrangement
DC219	Denial Reason	Text	15	Denial reason code. Required when denied claim indicator = 2 or 4 http://www.wpc-edi.com/reference/
DC899	Record Type	Text	2	DC

Appendix A-5: Provider File Data Tables

Table A-5(i) Provider File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
HD001	Record Type	Text	2	HD
HD002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
HD003	National Plan ID	Text	30	CMS National Plan ID
HD004	Type of File	Text	2	MP Provider File
HD005	Period Beginning Date	Date	8	Beginning of span of coverage period
HD006	Period Ending Date	date	8	End of span of coverage period
HD008	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Table A-5(ii) Provider File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
TR001	Record Type	Text	2	TR
TR002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
TR003	National Plan ID	Text	30	CMS National Plan ID
TR004	Type of File	Text	2	MP Provider File
TR005	Period Beginning Date	Date	8	Beginning of span of coverage period
TR006	Period Ending Date	Date	8	End of span of coverage period
TR007	Extraction Date	Date	8	Date file was created
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file

Table A-5(iii) Provider File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MP001	Payer	Text	8	Payer submitting payments. NHID Submitter Code
MP002	Plan ID	Text	30	CMS National Plan ID or NAIC code.
MP003	Provider ID	Text	30	Unique identified for the provider as assigned by the reporting entity
MP004	Provider Tax ID	Text	10	Tax ID of the provider. Do not code punctuation.
MP005	Provider Entity	Text	1	Specify the value that defines the type of entity
				1 Person; physician, clinician, orthodontist, and any individual that is licensed/certified to perform health care services.
				2 Facility; hospital, health center, long term care, rehabilitation and any building that is licensed to transact health care services.
				3 Professional Group; collection of licensed/certified health care professionals that are practicing health care services under the same entity name and Federal Tax Identification Number.
				4 Retail Site; brick-and-mortar licensed/certified place of transaction that is not solely a health care entity, i.e., pharmacies, independent laboratories, vision services.
				5 E-Site; internet-based order/logistic system of health care services, typically in the form of durable medical equipment, pharmacy or vision services. Address assigned should be the address of the company delivering services or order fulfillment.
				6 Financial Parent; financial governing body that does not perform health care services itself but directs and finances health care service entities, usually through a Board of Directors.
				7 Transportation; any form of transport that conveys a patient to/from a healthcare provider.
				8 Other; any type of entity not otherwise defined that performs health care services.
MP005	Provider First	Text	35	Individual first name. Leave blank if provider is a facility or organization

Table A-5(iii) Provider File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
	Name			
MP006	Provider Middle Name or Initial	Text	25	
MP007	Provider Last Name or Organization Name	Text	60	Full name of provider organization or last name of individual provider
MP008	Provider Suffix	Text	10	Example: Jr; Set as leave blank if provider is an organization. Do not use credentials such as MD or PhD
MP009	Provider Specialty	Text	10	Report the HIPAA-compliant health care provider taxonomy code. Code set is freely available at the National Uniform Claims Committee's web site at http://www.nucc.org/
MP010	Provider Office Street Address	Text	50	Physical address – address where provider delivers health care services
MP011	Provider Office City	Text	30	Physical address – address where provider delivers health care services
MP012	Provider Office State	Text	2	Physical address – address where provider delivers health care services. Use postal service standard 2 letter abbreviations
MP013	Provider Office Zip	Text	9	Physical address – address where provider delivers health care services. Minimum 5 digit code. Do not include dashes
MP014	Provider DEA Number	Text	12	
MP015	Provider NPI	Text	20	
MP016	Provider State License Number	Text	30	
MP017	Entity Code	Text	2	Enter the value that defines the entity provider type. Required when MP003 does not = 1
				1 Academic Institution
				2 Adult Foster Care

Table A-5(iii) Provider File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				3 Ambulance Services
				4 Hospital Based Clinic
				5 Stand-Alone, Walk-In/Urgent Care Clinic
				6 Other Clinic
				7 Community Health Center - General
				8 Community Health Center - Urgent Care
				9 Government Agency
				10 Health Care Corporation
				11 Home Health Agency
				12 Acute Hospital
				13 Chronic Hospital
				14 Rehabilitation Hospital
				15 Psychiatric Hospital
				16 DPH Hospital
				17 State Hospital
				21 Licensed Hospital Satellite Emergency Facility
				22 Hospital Emergency Center
				23 Nursing Home
MP899	Record Type	Text	2	MP

Appendix B: Data Submission Manual Code Tables

Appendix B-1: Insurance Type/Product Code – Eligibility File

Code	Description
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-Fault Insurance including Insurance in which Auto Is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
17	Dental
18	Vision
19	Prescription Drugs
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
AP	Auto Insurance Policy
C1	Commercial
CO	Consolidated Omnibus Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary

Code	Description
D	Disability
DB	Disability Benefits
E	Medicare – Point of Service (POS)
EP	Exclusive Provider Organization
FI	Federal Employees Health Benefits Program
FF	Family or Friends
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary

Code	Description
OT	Other
PE	Property Insurance – Personal
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance – Real
SP	Supplemental Policy
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
TR	Tricare
U	Multiple Options Health Plan
VA	Veterans Administration Plan
WU	Wrap Up Policy

Appendix B-2: Relationship Codes

Code	Description
01	Spouse
02	Son or daughter
03	Father or Mother
04	Grandfather or Grandmother
05	Grandson or Granddaughter

Code	Description
06	Uncle or Aunt
07	Nephew or Niece
08	Cousin
09	Adopted Child
10	Foster Child
11	Son-in-Law or Daughter-in-Law
12	Brother-in-Law or Sister-in-Law
13	Mother-in-Law or Sister-in-Law
14	Brother or Sister
15	Ward
16	Stepparent
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee/Self
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
25	Ex-spouse
26	Guardian
27	Student

Code	Description
28	Friend
29	Significant Other
30	Both Parents
31	Court Appointed Guardian
32	Mother
33	Father
34	Other Adult
36	Emancipated Minor
37	Agency Representative
38	Collateral Dependent
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
76	Dependent

Appendix B-3: Race 1/Race 2

Code	Description
R1	American Indian/Alaska Native
R2	Asian

R3	Black/African American
R4	Native Hawaiian or Other Pacific Islander
R5	White
R9	Other Race
UNKOW	Unknown/Not Specified

Appendix B-4: Ethnicity 1/Ethnicity 2

Code	Description
2182-4	Cuban
2184-0	Dominican
2148-5	Mexican, Mexican American, Chicano
2180-8	Puerto Rican
2161-8	Salvadoran
2155-0	Central American (not otherwise specified)
2165-9	South American (not otherwise specified)
2060-2	African
2058-6	African American
AMERCN	American
2028-9	Asian
2029-7	Asian Indian
BRAZIL	Brazilian
2033-9	Cambodian

Code	Description
CVERDN	Cape Verdean
CARIBI	Caribbean Island
2034-7	Chinese
2169-1	Columbian
2108-9	European
2036-2	Filipino
2157-6	Guatemalan
2071-9	Haitian
2158-4	Honduran
2039-6	Japanese
2040-4	Korean
2041-2	Laotian
2118-8	Middle Eastern
PORTUG	Portuguese
RUSSIA	Russian
EASTEU	Eastern European
2047-9	Vietnamese
OTHER	Other Ethnicity
UNKNOW	Unknown/Not Specified

Appendix B-5: Insurance Type/Product Code – Claims Files

Code	Description
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Advantage/Risk
17	Dental Maintenance Organization
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Company
DS	Disability
FI	Federal Employees Health Benefits Program
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MD	Medicare Part D

OF	Other Federal Program (e.g., Black Lung)
SP	Supplemental Policy
TR	Tricare
TV	Title V
VA	Veterans Administration Plan
ZZ	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)

Appendix B-6: Discharge Status

Code	Description
01	Discharged to home or self-care
02	Discharged/transferred to another short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to a facility that provides custodial or supportive care
05	Discharged/transferred to a designated cancer center of children's hospital
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Reserved for assignment by the NUBC
09	Admitted as an inpatient to this hospital
20	Expired
21	Discharged/transferred to court/law enforcement
30	Still patient or expected to return for outpatient services

Code	Description
40	Expired at home
41	Expired in a medical facility
42	Expired, place unknown
43	Discharged/ transferred to a Federal Hospital
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63	Discharged/transferred to a long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a critical access hospital (CAH)
69	Discharged/transferred to a designated disaster alternative care site (effective 10/1/13)
70	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission (effective 10/1/13)
82	Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission (effective 10/1/13)

Code	Description
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (effective 10/1/13)
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (effective 10/1/13)
85	Discharged/transferred to designated cancer center of children's hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (effective 10/1/13)
87	Discharged/transferred to court / law enforcement with a planned acute care hospital inpatient readmission (effective 10/1/13)
88	Discharged/transferred to a federal healthcare facility with a planned acute care hospital inpatient readmission (effective 10/1/13)
89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (effective 10/1/13)
90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)
93	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)

Code	Description
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
95	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)

Appendix B-7: Place of Service – Professional

Code	Description
01	Pharmacy
02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
09	Prison/Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility Congregate

Code	Description
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance – Land
42	Ambulance – Air or Water
43-48	Unassigned

Code	Description
50	Federally Qualified Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End Stage Renal Disease Treatment Facility
66-70	Unassigned
71	State or Local Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Unlisted Facility

Appendix B-8: Claim Status

Code	Description
01	Processed as primary
02	Processed as secondary
03	Processed as tertiary
04	Denied
05	Pended
06	Approved as amended
07	Approved as submitted
08	Cancelled due to inactivity
09	Pending – under investigation
10	Received, but not in progress
11	Rejected, duplicate claim
12	Rejected, please resubmit with corrections
13	Suspended
14	Suspended - incomplete claim
15	Suspended - investigation with field
16	Suspended - return with material
17	Suspended - review pending
18	Suspended Product Registration
19	Processed as primary, forwarded to additional payer(s)
20	Processed as secondary, forwarded to additional payer(s)

Code	Description
21	Processed as tertiary, forwarded to additional payer(s)
22	Reversal of previous payment
23	Not Our Claim, Forwarded to Additional Payer(s)
24	Transferred to Proper Carrier
25	Predetermination Pricing Only - No Payment
26	Documentation Claim - No Payment Associated
27	Reviewed
28	Repriced
29	Audited
30	Processed as Conditional
31	Not Our Claim, Unable to Forward
AD	Additional
AP	Appeal
CC	Weekly Certification
CL	Closed
CP	Open
I	Initial
RA	Re-audited
RB	Reissue
RC	Reopened and closed
RD	Redetermination
RO	Reopened

Appendix B-9 MC021 Point of Origin Codes

If MC020 = 4 (Newborn), then use the following values at MC021:

Code	Description
5	Born Inside the Hospital
6	Born Outside the Hospital

For all other values at MC020, use the following table for MC021:

Code	Description
1	Non-Healthcare Facility Point of Origin (Physician Referral)
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital (Different Facility)
5	Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available

Code	Description
A	Reserved for National Assignment
B	Transfer from Another Home Health Agency(Discontinued July 1,2010)
C	Readmission to Same Home Health Agency (Discontinued July 1,2010)
D	Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer
E	Transfer from Ambulatory Surgical Center
F	Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in Hospice Program

Appendix C: Mapping and Format Information

Appendix C-1: Member Eligibility File Mapping and Format Information

Data Element #	Element	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element
ME001	Payer	N/A
ME002	National Plan ID	271/2100A/NM1/XV/09
ME003	Insurance Type Code/Product	271/2110C/EB/ /04, 271/2110D/EB/ /04
ME004	Year	N/A
ME005	Month	N/A
ME006	Insured Group or Policy Number	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02
ME007	Coverage Level Code	271/2110C/EB/ /03, 271/2100D/EB/ /03
ME008	Encrypted Subscriber Social Security Number	271/2100C/NM1/MI/09
ME009	Plan Specific Contract Number	271/2100C/NM1/MI/09
ME010	Member Suffix or Sequence Number	N/A
ME011	Member Identification Code	271/2100C/MN1/MI/09, 271/2100D/NM1/MI/09
ME012	Individual Relationship Code	271/2100C/INS/Y/02, 271/2100D/INS/N/02
ME013	Member Gender	271/2100C/DMG/ /03, 271/2100D/DMG/ /03
ME014	Member Date of Birth	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02
ME015	Member City Name	271/2100C/N4/ /01, 271/2100D/N4/ /01
ME016	Member State or Province	217/2100C/N4/ /02, 271/2100D/N4/ /02

Data Element #	Element	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element
ME017	Member ZIP Code	271/2100C/N4/ /03, 271/2100D/N4/ /03
ME018	Medical Coverage	N/A
ME019	Prescription Drug Coverage	N/A
ME020	Race 1	N/A
ME021	Race 2	N/A
ME022	Dental Coverage	N/A
ME023	Place holder	N/A
ME024	Hispanic Indicator	N/A
ME025	Ethnicity 1	N/A
ME026	Ethnicity 2	N/A
ME027	Place holder	N/A
ME028	Primary Insurance Indicator	N/A
ME029	Coverage Type	N/A
ME030	Market Category	N/A
ME031	Special Coverage	N/A
ME032	Group Name	N/A
ME101	Encrypted Subscriber Last Name	270/2100C/NM1/IL/1/3
ME102	Encrypted Subscriber First Name	270/2100C/NM1/IL/1/4
ME103	Encrypted Subscriber Middle Initial	270/2100C/NM1/IL/1/5
ME104	Encrypted Member Last Name	270/2100D/NM1/QC/1/3
ME105	Encrypted Member First Name	270/2100D/NM1/QC/1/4
ME106	Encrypted Member Middle Initial	270/2100D/NM1/QC/1/5
ME899	Record Type	N/A

Appendix C-2: Medical Claims File Mapping and Format Information

Data Element #	Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type/ Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element
MC001	Payer	N/A	N/A	N/A	N/A	N/A
MC002	National Plan ID	N/A	N/A	N/A	N/A	835/1000A/N1/XV/04
MC003	Product/Claim Filing Indicator Code	N/A	30/4	N/A	N/A	835/2100/CLP/ /06
MC004	Payer Claim Control Number	N/A	N/A	N/A	FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0	835/2100/CLP/ /07
MC005	Line Counter	N/A	N/A	N/A	N/A	837/2400/LX/ /01
MC006	Insured Group or Policy Number	62 (A-C)	30/10	11C	DA0-10.0	837/2000B/SBR/ /03
MC007	Encrypted Subscriber Social Security Number	N/A	N/A	N/A	N/A	835/2100/NM1/34/08
MC008	Plan Specific Contract Number	N/A	N/A	N/A	N/A	835/2100/NM1/HN/08

Data Element #	Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type/ Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element
MC009	Member Suffix or Sequence Number	N/A	N/A	N/A	N/A	N/A
MC010	Member Identification Code	N/A	N/A	N/A	N/A	835/2100/NM1/34/08
MC011	Individual Relationship Code	59 (A-C)	30/18	6	DA0-17.0	8 37/2000B/SBR/ /02, 837/2000C/PAT/ /01
MC012	Member Gender	15	20/7	3	CA0-09.0	837/2010CA/DMG/03
MC013	Member Date of Birth	14	20/8	3	CA0-08.0	837/2010CA/DMG/D8/02
MC014	Member City Name	13	20/14	5	CA0-13.0	837/2010CA/N4/ /01
MC015	Member State or Province	13	20/15	5	CA0-14.0	837/2010CA/N4/ /02
MC016	Member ZIP Code	13	20/16	5	CA0-15.0	837/2010CA/N4/ /03
MC017	Paid Date/Date Service Approved	N/A	N/A	N/A	N/A	N/A
MC018	Admission Date	17	20/17	N/A	N/A	837/2300/DTP/435/03
MC019	Admission Hour	18	20/18	N/A	N/A	837/2300/DTP/435/03
MC020	Admission Type	19	20/10	N/A	N/A	837/2300/CL1/ /01
MC021	Admission Source	20	20/11		N/A	837/2300/CL1/ /02
MC022	Discharge Hour	21	20/22		N/A	837/2300/DTP/096/03
MC023	Discharge Status	22	20/21	N/A	N/A	837/2300/CL1/ /03

Data Element #	Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type/ Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element
MC024	Service Provider Number	N/A	N/A	N/A	N/A	N/A
MC025	Service Provider Tax ID Number	5	10/4-5	25	BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0,BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0,BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0	835/2100/NM1/FI/09
MC026	National Service Provider ID	N/A	10/6	N/A	N/A	835/2100/NM1/XX/09
MC027	Service Provider Entity Type Qualifier	N/A	N/A	N/A	N/A	835/2100/NM1/82/02
MC028	Service Provider First Name	1	10/12	33	BA0-20.0	835/2100/NM1/82/04
MC029	Service Provider Middle Name	1	10/12	33	BA0-21.0	835/2100/NM1/82/05
MC030	Service Provider	1	10/12	33	BA0-18.0,	835/2100/NM1/82/03

Data Element #	Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type/ Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element
	Last Name or Organization Name				BA0-19.0	
MC031	Service Provider Suffix	1	10/12	33	BA0-22.0	835/2100/NM1/82/07
MC032	Service Provider Specialty	N/A	N/A	N/A	N/A	837/2000A/PRV/ZZ/03
MC033	Service Provider City Name	1	10/14	N/A	BA1-09.0, 15.0	837/2010A/N4/ /01
MC034	Service Provider State or Province	1	10/15	N/A	BA1-10.0, 16.0	837/2010A/N4/ /02
MC035	Service Provider ZIP Code	1	10/16	N/A	BA1-11.0, 17.0	837/2010A/N4/ /03
MC036	Type of Bill – Institutional	4	Positions 1-2: 40/4	N/A	N/A	837/2300/CLM/ /05-1
MC037	Facility Type - Professional	N/A	N/A	N/A	FA0-07.0, GU0-0.50	835/2100/CLP/ /08
MC038	Claim Status	N/A	N/A	N/A	N/A	835/2100/CLP/ /02
MC039	Admitting Diagnosis	76	70/25	N/A	N/A	837/2300/HI/BJ/02-2
MC040	E-Code	77	70/26	N/A	N/A	837/2300/HI/BN/03-2
MC041	Principal Diagnosis	67	70/4	21.1	EA0-32.0, GX0-31.0, GU0-12.0	837/2300/HI/BK/01-2
MC042	Other Diagnosis – 1	68	70/5	21.2	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-1

Data Element #	Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type/ Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element
MC043	Other Diagnosis – 2	69	70/6	21.3	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-2
MC044	Other Diagnosis – 3	70	70/7	21.4	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-3
MC045	Other Diagnosis – 4	71	70/8	N/A	EA0-35.0, GX0-34.0, GU0-15.0	837/2300/HI/BF/02-4
MC046	Other Diagnosis – 5	72	70/9	N/A	N/A	837/2300/HI/BF/02-5
MC047	Other Diagnosis – 6	73	70/10	N/A	N/A	837/2300/HI/BF/02-6
MC048	Other Diagnosis – 7	74	70/11	N/A	N/A	837/2300/HI/BF/02-7
MC049	Other Diagnosis – 8	75	70/12	N/A	N/A	837/2300/HI/BF/02-8
MC050	Other Diagnosis – 9	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-9
MC051	Other Diagnosis –10	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-10
MC052	Other Diagnosis –11	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-11
MC053	Other Diagnosis –12	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-12
MC054	Revenue Code	42	50/5,11-13, 60/5,15-16, 61/5,15-16	N/A	N/A	835/2110/SVC/RB/01-2, 835/2110/SVC/NU/01-2

Data Element #	Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type/ Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element
MC055	Procedure Code	44	60/6,15-16, 61/6,15-16	24.1-6 D	FA0-09.0, FB0-15.0, GU0-07.0	835/2110/SVC/HC/01-2
MC056	Procedure Modifier – 1	44	60/7,15-16, 61/7, 15-16	24.1-6 D	FA0-10.0, GU0-08.0	835/2110/SVC/HC/01-3
MC057	Procedure Modifier – 2	44	60/8,15-16, 61/8,15-16	24.1-6 D	FA0-11.0	835/2110/SVC/HC/01-3
MC058	ICD-9-CM Procedure Code	80, 81(A-E)	70/13, 15, 17, 19, 21, 23	N/A	N/A	835/2110/SVC/ID/01-2
MC059	Date of Service – From	45	61/13, 15-16, 61/13, 15-16	24.1-6 A	N/A	835/2110/DTM/150/02
MC060	Date of Service – Thru	N/A	N/A	24.1-6 A	FA0-05.0, FA0-06.0	835/2110/DTM/151/02
MC061	Quantity	46	50/7, 11-13, 60/9,15-16, 61/9,15-16	24.1-6 G	FA0-19.0, FB0-16.0	835/2110/SVC/ /05
MC062	Charge Amount	47	50/8, 11-13, 60/10, 16-16, 61/11, 15-16	24.1-6F	FA0-13.0	835/2110/SVC/ /02
MC063	Paid Amount	48	N/A	N/A	N/A	835/2110/SVC/ /03
MC064	Prepaid Amount	N/A	N/A	N/A	N/A	N/A
MC065	Co-pay Amount	N/A	N/A	N/A	N/A	N/A
MC066	Coinsurance Amount	N/A	N/A	N/A	N/A	N/A
MC067	Deductible Amount	N/A	N/A	N/A	N/A	N/A
MC068	Patient Account/Control	3	N/A	N/A		837/2300/CLM/1

Data Element #	Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type/ Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element
	Number					
MC069	Discharge Date					
MC070	Service Provider Country Name					
MC071	DRG	N/A	N/A	N/A	N/A	837/2300/HI/DR/2
MC072	DRG Version	N/A	N/A	N/A	N/A	N/A
MC073	APC	N/A	N/A	N/A	N/A	N/A
MC074	APC Version	N/A	N/A	N/A	N/A	N/A
MC075	Drug Code	N/A				837/2400/SV2/N1/2 837/2400/SV2/N2/2 837/2400/SV2/N3/2 837/2400/SV2/N4/2 837/2400/SV2/ND/2
MC101	Encrypted Subscriber Last Name					837/2110BA/NM1/IL/1/3
MC102	Encrypted Subscriber First Name					837/2110BA/NM1/IL/1/4
MC103	Encrypted Subscriber Middle Initial					837/2110BA/NM1/IL/1/5
MC104	Encrypted Member Last Name					837/2110CA/NM1/QC/1/3
MC105	Encrypted Member First Name					837/2110CA/NM1/QC/1/4

Data Element #	Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type/ Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element
MC106	Encrypted Member Middle Initial					837/2110CA/NM1/QC/1/5

Appendix C-3: Pharmacy Claims Mapping and Format Information

Data Element	Element	National Council for Prescription Drug Programs Field #
PC001	Payer	N/A
PC002	Plan ID	N/A
PC003	Insurance Type/Product Code	N/A
PC004	Payer Claim Control Number	N/A
PC005	Line Counter	N/A
PC006	Insured Group Number	301-C1
PC007	Encrypted Subscriber Social Security Number	302-C2
PC008	Plan Specific Contract Number	N/A
PC009	Member Suffix or Sequence Number	N/A
PC010	Member Identification Code	302-CY
PC011	Individual Relationship Code	306-C6
PC012	Member Gender	305-C5
PC013	Member Date of Birth	304-C4
PC014	Member City Name of Residence	323-CN
PC015	Member State or Province	324-CO
PC016	Member ZIP Code	325-CP
PC017	Date Service Approved (AP Date)	N/A
PC018	Pharmacy Number	202-B2
PC019	Pharmacy Tax ID Number	N/A
PC020	Pharmacy Name	833-5P
PC021	National Pharmacy ID Number	N/A
PC022	Pharmacy Location City	831-5N
PC023	Pharmacy Location State	832-6F

Data Element	Element	National Council for Prescription Drug Programs Field #
PC024	Pharmacy ZIP Code	835-5R
PC025	Claim Status	N/A
PC026	Drug Code	407-D7
PC027	Drug Name	516-FG
PV028	New Prescription	403-D3
PC029	Generic Drug Indicator	N/A
PC030	Dispense as Written Code	408-D8
PC031	Compound Drug Indicator	406-D6
PC032	Date Prescription Filled	401-D1
PC033	Quantity Dispensed	442-E7
PC034	Days Supply	405-D5
PC035	Charge Amount	804-5B
PC036	Paid Amount	509-F9
PC037	Ingredient Cost/List Price	506-F6
PC038	Postage Amount Claimed	428-DS
PC039	Dispensing Fee	507-F7
PC040	Copay Amount	518-FI
PC041	Coinsurance Amount	518-FI
PC042	Deductible Amount	505-F5
PC043	Record Type	N/A

Appendix C-4: Dental Claim Mapping and Format Information

Data Element #	Data Element Name	NSF (National Standard Format) Locator	
DC001	Payer	N/A	
DC002	National Plan Id	N/A	
DC003	Insurance Type/Product Code	N/A	
DC004	Payer Claim Control Number	N/A	
DC005	Line Counter	FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0GU0-02.0	
DC006	Insured Group or Policy Number	DA0-10.0	
DC007	Encrypted Subscriber Social Security Number	N/A	
DC008	Plan Specific Contract Number	N/A	
DC009	Member Suffix or Sequence Number	N/A	
DC010	Member Identification Code	N/A	
DC011	Individual Relationship Code	DA0-17.0	837/20
DC012	Member Gender	CA0-09.0	
DC013	Member Date of Birth	CA0-08.0	
DC014	Member City Name of Residence	CA0-13.0	
DC015	Member State or Province	CA0-14.0	
DC016	Member ZIP Code of Residence	CA0-15.0	
DC017	Date Service Approved	N/A	
DC018	Service Provider Number	N/A	835/210 835/210

Data Element #	Data Element Name	NSF (National Standard Format) Locator	
DC019	Service Provider Tax ID Number	BA0-09.0, CA0-28.0, BA0-02.0,BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0,BA0-17.0, BA0-24.0, YA0-06.0	
DC020	National Service Provider ID	N/A	
DC021	Service Provider Entity Type Qualifier	N/A	
DC022	Service Provider First Name	BA0-20.0	
DC023	Service Provider Middle Name	BA0-21.0	
DC024	Service Provider Last Name or Organization Name	BA0-18.0, BA0-19.0	
DC025	Service Provider Suffix	BA0-22.0	
DC026	Service Provider Specialty	N/A	
DC027	Service Provider City name	BA1-09.0, 15.0	
DC028	Service Provider State or Province	BA1-10.0, 16.0	
DC029	Service Provider ZIP Code	BA1-11.0, 17.0	
DC030	Facility Type - Professional	FA0-07.0, GU0-0.50	
DC031	Claim Status		
DC032	CDT Code	FA0-09.0, FB0-15.0, GU0-07.0	835/2110
DC033	Procedure Modifier - 1	FA0-10.0, GU0-08.0	
DC034	Procedure Modifier - 2	FA0-11.0	
DC035	Date of Service - From	N/A	
DC036	Date of Service - Thru	FA0-05.0, FA0-06.0	
DC037	Charge Amount	FA0-13.0	
DC038	Paid Amount	N/A	
DC039	Copay Amount	N/A	
DC040	Coinsurance Amount	N/A	

Data Element #	Data Element Name	NSF (National Standard Format) Locator	
DC041	Deductible Amount	N/A	
DC042	Record Type	N/A	
DC043	Billing Provider Number	N/A	835/2100
DC044	National Billing Provider ID	N/A	835/2110
DC045	Billing Provider Last Name	N/A	835/2110
DC101	Encrypted Subscriber Last Name		
DC102	Encrypted Subscriber First Name		
DC103	Encrypted Subscriber Middle Initial		
DC104	Encrypted Member Last Name		
DC105	Encrypted Member First Name		
DC106	Encrypted Member Middle Initial		
DC899	Record Type	N/A	