

COLORADO DIVISION OF WORKERS' COMPENSATION
IAIABC FROI DATA ELEMENT MATRIX - Release 1
For MTC Code 00, Original; 02, Change; CO, Correction; and 01, Cancel
Revised 8/01/02

GROUPING	DATA NUMBER	DATA NAME	FIELD FORMAT	MTC 00 CARDINALITY	MTC 02 CARDINALITY	MTC CO CARDINALITY	MTC 01 CARDINALITY
TRANSACTION	1	Transaction Set ID	3 A/N	M	M	M	M
	2	Maintenance Type Code	2 A/N	M	M	M	M
	3	Maintenance Type Code Date	DATE	M	M	M	M
JURISDICTION	4	Jurisdiction	2 A/N	M	M	M	M
	5	Agency Claim Number	25 A/N	NA	M	M	M
CLAIM ADMINISTRATOR	6	Insurer FEIN	9 A/N	M	M	M	O
	7	Insurer Name	30 A/N	M	M	M	O
	8	Third Party Administrator FEIN	9 A/N	C1	C1	C1	O
	9	Third Party Administrator Name	30 A/N	C1	C1	C1	O
	10	Claim Administrator Address Line 1	30 A/N	O	O	O	O
	11	Claim Administrator Address Line 2	30 A/N	O	O	O	O
	12	Claim Administrator City	15 A/N	O	O	O	O
	13	Claim Administrator State	2 A/N	O	O	O	O

Cardinality Legend

M = This field is mandatory and if not present will cause record to reject.

C1 = This field is required if conditions warrant. Example: If a TPA is administering the claim, the TPA fields would be required. See listing at end of document.

C2 = This field is required before a position statement can be entered. Explanation: This information is needed by the Division to provide statistical information to the Colorado Legislature.

O = Optional

NA = Not applicable to Initial First Reports. Required for corrections (MTC CO) and changes (MTC 02).

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	14	Claim Administrator Postal Code	9 A/N	C1	C1	C1	O
	15	Claim Administrator Claim Number	25 A/N	M	M	M	M
INSURED	16	Employer FEIN	9 A/N	M	M	M	O
	17	Insured Name	30 A/N	M	M	M	O
	18	Employer Name	30 A/N	M	M	M	O
	19	Employer Address Line 1	30 A/N	M	M	M	O
	20	Employer Address Line 2	30 A/N	C1	C1	C1	O
	21	Employer City	15 A/N	M	M	M	O
	22	Employer State	2 A/N	M	M	M	O
	23	Employer Postal Code	9 A/N	M	M	M	O
	24	Self Insured Indicator	1 A/N	M	M	M	O
	25	Industry Code	6 A/N	O	O	O	O
	26	Insured Report Number	10 A/N	O	O	O	O
	27	Insured Location Number	15 A/N	O	O	O	O
POLICY	28	Policy Number	30 A/N	O	O	O	O
	29	Policy Effective Date	DATE	O	O	O	O

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	30	Policy Expiration Date	DATE	O	O	O	O
ACCIDENT	31	Date of Injury	DATE	M	M	M	M
	32	Time of Injury	HHMM	O	O	O	O
	33	Postal Code of Injury Site	9 A/N	C1	C1	C1	O
	34	Employer's Premises Indicator	1 A/N	M	M	M	O
	35	Nature of Injury Code	2 A/N	M	M	M	O
	36	Part of Body Injured Code	2 A/N	M	M	M	O
	37	Cause of Injury Code	2 A/N	M	M	M	O
	38	Accident Description/Cause	150 A/N	M	M	M	O
	39	Initial Treatment	2 A/N	O	O	O	O
	40	Date Reported to Employer	DATE	M	M	M	O
	41	Date Reported to Claim Administrator	DATE	M	M	M	O
EMPLOYEE	42	Social Security Number	9 A/N	M	M	M	M
	43	Employee Last Name	30 A/N	M	M	M	O
	44	Employee First Name	15 A/N	M	M	M	O
	45	Employee Middle Initial	1 A/N	O	O	O	O

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	46	Employee Address Line 1	30 A/N	M	M	M	O
	47	Employee Address Line 2	30 A/N	C1	C1	C1	O
	48	Employee City	15 A/N	M	M	M	O
	49	Employee State	2 A/N	M	M	M	O
	50	Employee Postal Code	9 A/N	M	M	M	O
	51	Employee Phone	10 A/N	O	O	O	O
	52	Employee Date of Birth	DATE	M	M	M	O
	53	Gender Code	1 A/N	M	M	M	O
	54	Marital Status Code	1 A/N	O	O	O	O
	55	Number of Dependents	2 A/N	C1	C1	C1	O
	56	Date Disability Began	DATE	O	O	O	O
	57	Employee Date of Death	DATE	C1	C1	C1	O
EMPLOYMENT	58	Employment Status Code	2 A/N	M	M	M	O
	59	Class Code	4 A/N	O	O	O	O
	60	Occupation Description	30 A/N	O	O	O	O
	61	Date of Hire	DATE	O	O	O	O
	62	Wage	\$9.2	C2	C2	C2	O

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	63	Wage Period	2 A/N	C1	C1	C1	O
	64	Number of Days Worked	1 N	C1	C1	C1	O
	65	Date Last Day Worked	DATE	O	O	O	O
	66	Full Wages Paid for Date of Injury Indicator	1 A/N	M	M	M	O
	67	Salary Continued Indicator	1 A/N	M	M	M	O
	68	Date of Return to Work	DATE	O	O	O	O

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Explanation of Conditional Data Elements, C1 and C2

C1

DN #	Name	Explanation
8	TPA Fein	If a TPA is sending this record, include that TPA's Federal Identification Number (FEIN).
9	TPA Name	If DN 8, TPA FEIN, is entered, the corresponding TPA Name is mandatory.
14	TPA Postal Code	If DN 8, TPA FEIN is entered, the TPA 9-digit Postal Code is mandatory.
20	Employer Address Line 2	If the employer has an address that fills two lines, enter this portion of the address.
33	Postal Code of Injury Site	If the mandatory element DN 34, Employer Premises Indicator, is marked "N" - not on employer premises, enter the Postal Code of Injury Site.
47	Employee Address Line 2	If the employee has an address that fills two lines, enter this portion of the address.
55	Number of Dependents	If the employee has died and this is a fatal First Report, enter the number of Dependents. Values are 00-99. If the employee has not died, do not enter anything in this field.
57	Date of Death	If the employee has died as a result of the injury, enter the Date of Death. Otherwise, leave it blank.
63	Wage Period	If DN 62, Wage, is entered, you must enter the Wage Period Code. Valid values are 01, 02, 04, and 06.
64	Number of Days Worked	If TTD benefits are likely to be paid, DN 64, Number of Days Worked, is required. The data is used to calculate waiting period and dates payable.

C2

DN #	Name	Explanation
62	Wage	Required before a position statement can be submitted.