CENTER FOR IMPROVING VALUE IN HEALTH CARE (CIVHC)

Colorado All-Payer Claims Database DATA SUBMISSION GUIDE

August 2011 v2

REVISION HISTORY

Date	Version	Description	Author
2/1/2011	A	Initial draft	A. Graziano
2/2/2011	B	Added section on Data Quality Requirements and added Employer Name to the Eligibility Data File. Added Provider File and Pharmacy Eligibility File, with placeholder for Plan Details File.	A. Graziano
3/1/2011	C	General revisions and updates	A. Graziano
3/21/2011	D	Added section numbering and data elements to insurance plan file. Added decisions reached during payer weekly DSG meeting	
4/27/2011	0	Incorporated decisions reached during payer weekly meetings including a revision to submission timelines, modification to data element definitions	A. Graziano
6/10/2011	0	Final adjustments made based on feedback from Cigna and United Healthcare. Modified timeline for data submission.	A. Graziano
7/14/11	1	Removed elements that are stated in the rule and removed certain data values in several data elements that are not relevant. Included the requirement to filter claims based on CRS 10-16-104(5)(d)(I)	A. Graziano
8/3/11	2	Modified data element types, removed reference to small group plan types and filtering of mental health related claims. Provided definitions for field types.	A. Graziano

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1.0 DATA SUBMISSION REQUIREMENTS - GENERAL

Data submissions detailed below will include eligibility, medical claims, pharmacy claims, provider data, and product data files (Health Care Data). Field definitions and other relevant data associated with these submissions are specified in Exhibit A. These datasets have been developed by the APCD Council in collaboration with stakeholders across the nation. Refer to APCD Rule 0615 for definitions and other requirements.

Each payer will be required to submit to administrator documentation supporting their standard data extract files that will include a data dictionary mapping internal system data elements to the data elements defined in this DSG. The documentation should include a detailed description of how the data extracts are created and how the requirements of this DSG and the rule are accomplished, including specifications on what data is being excluded and the parameters that define that excluded data.

1.1 DATA TO BE SUBMITTED

1.2.1 MEDICAL CLAIMS DATA

a) Payers shall report health care service paid claims and encounters for all Colorado resident members. Payers may be required to identify encounters corresponding to a capitation payment (Exhibit A-2).
b) A Colorado resident is defined as any eligible member whose residence is within the State of Colorado, and all covered dependents. An exception to this is subscribers covered under a student plan. In this case, any student enrolled in a student plan for a Colorado college/university would be considered a Colorado resident regardless of their address of record.
c) Payers must provide information to identify the type of service and setting in which the service was provided. Each submitted data file shall have control totals and transmission control data (see Exhibits for specifics).

   Claim data is required for submission for each month during which some action has `been taken on that claim (ie payment, adjustment or other modification). Any claims that have been "soft" denied (denied for incompleteness, incorrect or other administrative reasons) which the data supplier expects to be resubmitted upon correction, do not have to be submitted until corrections have been completed and the claim paid. It is desirable that payers provide a reference that links the original claim to all subsequent actions associated with that claim (see Exhibit A-2 for specifics).
d) ICD-9/ICD-10 Diagnosis and Procedure Codes are required to accurately report risk factors related to the Episode of Care. CPT/HCPCS codes are also required.
e) For historical data submitted during the onboarding process, payers shall provide as a separate report monthly totals of covered members (Colorado residents) for the periods associated with the Historical Data (1/1/2009 through 12/31/2011).

1.2.2 PHARMACY CLAIMS

a) Health Care Payers must provide data for all pharmacy paid claims for prescriptions that were actually dispensed to members and paid (Exhibit A-3).
b) If your health plan allows for medical coverage without pharmacy (or vice versa), ME018 – ME020 in Exhibit A-1 provides data elements in which such options must be identified in order to effectively and accurately aggregate claims based on Episodes of Care.

1.2.3 MEMBER ELIGIBILITY DATA

a) Health Care Payers must provide a data set that contains information on every covered plan member who is a Colorado resident (see paragraph 1.2.1.b above) whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity and language, and other required fields to allow retrieval of related information from pharmacy and medical claims data sets (Exhibit A).
b) If dual coverage exists, send coverage of eligible members where payer insurance is primary or tertiary. ME028 is a flag to indicate whether this insurance is primary or tertiary coverage.

1.2.4 PROVIDER DATA

a) Health Care Payers must provide a data set that contains information on every provider for whom claims were adjudicated during the targeted reporting period.
b) In the event the same provider delivered and was reimbursed for services rendered from two different physical locations, than the provider data file shall contain two separate records for that same provider reflecting each of those physical locations. One record shall be provided for each unique physical location for a provider.

2.0 FILE SUBMISSION METHODS

2.1. SFTP – Secure File Transport Protocol involves logging on to the appropriate FTP site and sending or receiving files using the SFTP client.
2.2 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.

3.0 DATA QUALITY REQUIREMENTS

3.1 The data elements in Exhibit A provide, in addition to field definitions, an indicator regarding data elements that are required. A data element that is required must contain a value unless a waiver is put in place with a specific payer who is unable to provide that data element due to system limitations. A data element marked as "TH" means that a % of all records must have a value in this field based on the expected frequency that this data element is available. Data files that don't achieve this threshold percentage for that data element may be rejected or require follow up prior to load into the APCD. A data element marked as "O" is an optional data element that should be provided when available, but otherwise may contain a null value.

3.2 Data validation and quality edits will be developed in collaboration with each payer and refined as test data and production data is brought into the APCD. Data files missing required fields, or when claim line/record line totals don't match, may be rejected on submission. Other data elements will be validated against established ranges as the database is populated and may require manual intervention in order to ensure the data is correct.

The objective is to populate the APCD with quality data and each payer will need to work interactively with CIVHC to develop data extracts that achieve validation and quality specifications. This is the purpose of test data submissions early in the implementation process. Waivers may be granted, at the discretion of CIVHC, for data variances that cannot be corrected due to systematic issues that require substantial effort to correct.

4.0 FILE FORMAT

4.1 All files submitted to the APCD will be formatted as standard text file.

Text files all comply with the following standards:

a) Always one line item per row; No single line item of data may contain carriage return or line feed characters.
b) All rows delimited by the carriage return + line feed character combination.
c) All fields are variable field length, delimited using the pipe character (ASCII=124). It is imperative that no pipes ('|') appear in the data itself. If your data contains pipes, either remove them or discuss using an alternate delimiter character.
d) Text fields are *never* demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data.
e) The first row *always* contains the names of data columns.
f) Unless otherwise stipulated, numbers (ID numbers, account numbers, etc) do not contain spaces, hyphens or other punctuation marks.

g) Text fields are never padded with leading or trailing spaces or tabs.
h) Numeric fields are never padded with leading or trailing zeros.
i) If a field is not available, or is not applicable, leave it blank. 'Blank' means do not supply any value at all between commas (including quotes or other characters).

5.0 DATA ELEMENT TYPES

date – date data type for dates from 1/1/0001 through 12/31/9999

int – integer (whole number)

tinyint – integer data from 0 through 255

decimal/numeric – fixed precision and scale numeric data

char – fixed length non-unicode data with a max of 8,000 characters

varchar – variable length non-unicode data with a maximum of 8,000 characters

text – variable length non-unicode data with a maximum of 2^31 -1 characters

EXHIBIT A - DATA ELEMENTS

A-1 ELIGIBILITY FOR MEDICAL CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

It is extremely important that the member ID (Member Suffix or Sequence Number) is unique to an individual and that this unique identifier in the eligibility file is consistent with the unique identifier in the medical claims/pharmacy file. This provides linkage between medical and pharmacy claims during established coverage periods and is critical for the implementation of Episode of Care reporting.

For Historic Data collected, eligibility is to be reported for all Colorado residents who were covered members during that reporting month. In the event historical address data is not available, eligibility data for historical months shall be reported based on member's last known or current address. It is acknowledged that for some payers there may not be an eligibility record for each member identified in the medical claims file for that same period. In order to reconcile the total number of Colorado resident covered members for this 3 year period, each payer is to submit a summary report that totals the number of Colorado resident covered members for each month for Historic Data.

Additional formatting requirements:

- Eligibility files are formatted to provide one record per member per month. Member is either the Subscriber or the Subscriber's dependents.
- Data for administration fees, premiums, and capitation fees is contained on the eligibility file is pre-allocated (i.e. broken out by employee by month) to match the eligibility data
- Payers submit data in a single, consistent format for each data type.

MEDICAL ELIGIBILITY FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values

HD001	Record Type	char	2	ME
HD002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	varchar	75	
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical eligibility file, excluding header and trailer records

MEDICAL ELIGIBILITY FILE TRAILER RECORD

Data Element #	Date Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	ME
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
TR003	Payer Name	varchar	75	
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMDD

A-1.1 MEDICAL ELIGIBILITY FILE

Date Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME001	N/A	Payer Name/Code	varchar	8	Payer submitting payments-assigned by CIVHC (may be multiple to support different platforms, or as required)	R
ME002	271/2100A /NM1/XV/ 09	National Plan ID	varchar	30	CMS National Plan ID or NAIC	O
ME003	271/2110C /EB/ /04, 271/2110D /EB/ /04	Insurance Type Code/Product	char	2	See Lookup Table B-1.A	
ME004	N/A	Year	int	4	4 digit Year for which eligibility is reported in this submission	R
ME005	N/A	Month	char	2	Month for which eligibility is reported in this submission expressed numerical from 01 to 12.	R
ME006	271/2100C /REF/1L/02 , 271/2100C /REF/IG/02 , 271/2100C /REF/6P/02 , 271/2100D	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber	R

	/REF/1L/02 , 271/2100D /REF/IG/02 , 271/2100D /REF/6P/02					
ME007	271/2110C /EB/ /02, 271/2110D /EB/ /02	Coverage Level Code	char	3	Benefit coverage level	R
					CHD Children Only	
					DEP Dependents Only	
					ECH Employee and Children	
					EPN Employee plus N where N equals the number of other covered dependents	
					ELF Employee and Life Partner	
					EMP Employee Only	
					ESP Employee and Spouse	
					FAM Family	
					IND Individual	
					SPC Spouse and Children	
					SPO Spouse Only	
ME008	271/2100C /NM1/MI/ 09	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	TH
ME009	271/2100C /NM1/MI/ 09	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R

ME010	N/A	Member Suffix or Sequence Number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member.	R
ME011	271/2100C /NM1/MI/ 09, 271/2100D /NM1/MI/ 09	Member Identification Code	varchar	9	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	TH
ME012	271/2100C /INS/Y/02, 271/2100D /INS/N/02	Individual Relationship Code	char	2	Member's relationship to insured – see Lookup Table B-1.B	R
ME013	271/2100C /DMG/ /03, 271/2100D /DMG/ /03	Member Gender	char	1	M – Male F – Female U - UNKNOWN	R
ME014	271/2100C /DMG/D8/ 02, 271/2100D /DMG/D8/ 02	Member Date of Birth	char	8	CCYYMMDD	R
ME015	271/2100C /N4/ /01, 271/2100D /N4/ /01	Member City Name	varchar	30	City location of member	R
ME016	271/2100C /N4/ /02, 271/2100D	Member State or Province	char	2	As defined by the US Postal Service	R

	/N4/ /02					
ME017	271/2100C /N4/ /03, 271/2100D /N4/ /03	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired.	R
ME018	N/A	Medical Coverage	char	1	Y – YES N - NO	R
ME019	N/A	Prescription Drug Coverage	char	1	Y – YES N - NO	R
ME020	N/A	Dental Coverage	char	1	Y – YES N – NO 3 - UNKNOWN	R
ME021	N/A	Race 1	varchar	6		O
					R1 American Indian/Alaska Native	
					R2 Asian	
					R3 Black/African American	
					R4 Native Hawaiian or other Pacific Islander	
					R5 White	
					R9 Other Race	
					UNKNOW Unknown/Not Specified	
ME022	N/A	Race 2	varchar	6	See code set for ME021.	O
ME023	N/A	Other Race	varchar	15	List race if MC021or MC022 are coded as R9.	O
ME024	N/A	Hispanic Indicator	char	1		O
					Y = Patient is Hispanic/Latino/Spanish	
					N = Patient is not Hispanic/Latino/Spanish	
					U = Unknown	

ME025	N/A	Ethnicity 1	varchar	6		O
					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	
					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	
ME026	N/A	Ethnicity 2	varchar	6	See code set for ME025.	O
ME027	N/A	Other Ethnicity	varchar	20	List ethnicity if MC025 or MC026 are coded as OTHER.	O
ME028	N/A	Primary Insurance Indicator	char	1	Y – Yes, primary insurance N – No, secondary or tertiary insurance	R
ME029	N/A	Coverage Type	char	3	STN – short-term, non-renewable health insurance (ie COBRA) UND – plans underwritten by the insurer OTH – any other plan. Insurers using this code shall obtain prior approval.	R
ME030	N/A	Market Category Code	varchar	4		O
					IND – policies sold and issued directly to individuals (non-group)	
					FCH – policies sold and issued directly to individuals on a franchise basis	
					GS3 – policies sold and issued directly to employers having 50 or more employees	
					GSA – policies sold and issued directly to small employers through a qualified association trust	
					OTH – policies sold to other types of entities. Insurers using this market code shall obtain prior approval.	

ME032	N/A	Group Name	varchar	128	Group name or IND for individual policies	O
ME043	N/A	Member Street Address	varchar	50	Street address of member	R
ME044	N/A	Employer Name	varchar	50	Name of the Employer, or if same as Group Name, null	O
ME101	271/2100C /NM1/ /03	Subscriber Last Name	varchar	128	The subscriber last name	R
ME102	271/2100C /NM1/ /04	Subscriber First Name	varchar	128	The subscriber first name	R
ME103	271/2100C /NM1/ /05	Subscriber Middle Initial	char	1	The subscriber middle initial	O
ME104	271/2100D /NM1/ /03	Member Last Name	varchar	128	The member last name	R
ME105	271/2100D /NM1/ /04	Member First Name	varchar	128	The member first name	R
ME897	N/A	Plan Effective Date	char	8	CCYYMMDD Date eligibility started for this member under this plan type. The purpose of this data element is to maintain eligibility span for each member.	R
ME899	N/A	Record Type	char	2	Value = ME	R

A-2 MEDICAL CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Claims are paid claims. Non-covered or denied claims (e.g. duplicate or patient ineligible claims) are not included.
- Payers submit data in a single, consistent format for each data type.

MEDICAL CLAIMS FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	MC
HD002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	varchar	75	Example:
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical claims file, excluding header and trailer records

MEDICAL CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	MC
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
TR003	Payer Name	varchar	75	
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMDD

A-2.1 MEDICAL CLAIMS FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC001	N/A	Payer	varchar	8	Payer submitting payments	R
MC002	837/2010BB/NM1/XV/09	National Plan ID	varchar	30	CMS National Plan ID	R
MC003	837/2000B/SBR/ /09	Insurance Type/Product Code	char	2	See Lookup Table B-1.B	R
MC004	835/2100/CLP/ /07	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system.	R
MC005	837/2400/LX/ /01	Line Counter	tinyint	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.	R
MC005A	N/A	Version Number	tinyint	4	The version number of this claim service line. The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line.	R

MC006	837/2000B/SBR/ /03	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber.	R
MC007	835/2100/NM1/34/ 09	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	TH
MC008	835/2100/NM1/HN/ 09	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
MC009	N/A	Member Suffix or Sequence Number	varchar	20	Unique number of the member within the contract. Must be an identifier that is unique to the member.	R
MC010	835/2100/NM1/MI/ 089	Member Identification Code (patient)	varchar	9	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	TH
MC011	837/2000B/SBR/ /02, 837/2000C/PAT/ /01, 837/2320/SBR/ /02	Individual Relationship Code	char	2	Member's relationship to insured – payers will map their available codes to those listed in Lookup Table B-1.B	R
MC012	837/2010CA/DMG/ /03	Member Gender	char	1	M - Male F – Female U - Unknown	R
MC013	837/2010CA/DMG/ D8/02	Member Date of Birth	char	8	CCYYMMDD	R

MC014	837/2010CA/N4/ /01	Member City Name	varchar	30	City name of member	R
MC107		Member Street Address	Varchar	50	Physical street address of the covered member	
MC015	837/2010CA/N4/ /02	Member State or Province	char	2	As defined by the US Postal Service	R
MC016	837/2010CA/N4/ /03	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Plus 4 optional but desired.	R
MC017	N/A	Date Service Approved/Accounts Payable Date/Actual Paid Date	char	8	CCYYMMDD	R
MC018	837/2300/DTP/435/ 03	Admission Date	char	8	Required for all inpatient claims. CCYYMMDD	O (inpatient claims only)
MC019	837/2300/DTP/435/ 03	Admission Hour	char	4	Required for all inpatient claims. Time is expressed in military time - HHMM	O (inpatient claims only)
MC020	837/2300/CL1/ /01	Admission Type	tinyint	1	Required for all inpatient claims (SOURCE: National Uniform Billing Data Element Specifications)	O (inpatient claims only)
					1 Emergency	
					2 Urgent	
					3 Elective	
					4 Newborn	
					5 Trauma Center	
					9 Information not available	
MC021	837/2300/CL1/ /02	Admission Source	char	1	Required for all inpatient claims (SOURCE: National Uniform Billing Data Element Specifications)	O (inpatient claims only)
MC022	837/2300/DTP/096/	Discharge Hour	tinyint	4	Time expressed in military time –	O (inpatient

	03				HHMM	claims only)
MC023	837/2300/CL1/ /03	Discharge Status	char	2	Required for all inpatient claims.	O (inpatient claims only)
					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 nursing facility (NF)	
					05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution	
					06 Discharged/transferred to home under care of organized home health service organization	
					07 Left against medical advice or discontinued care	
					08 Discharged/transferred to home under care of a Home IV provider	
					09 Admitted as an inpatient to this hospital	
					20 Expired	
					30 Still patient or expected to return for outpatient services	
					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	
MC024	835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09	Service Provider Number	varchar	30	Payer assigned service provider number, preferably for the individual provider but alternately for the clinic where the service occurred.	R
MC025	835/2100/NM1/FI/09	Service Provider Tax ID Number	varchar	10	Federal taxpayer's identification number	TH

MC026	professional: 837/2420A/NM1/XX/09; 837/2310B/NM1/XX/09; institutional: 837/2420A/NM1/XX/09; 837/2420C/NM1/XX/09; 837/2310A/NM1/XX/09	Service National Provider ID	varchar	20	National Provider ID. This data element pertains to the entity or individual directly providing the service.	TH
MC027	professional: 837/2420A/NM1/82/02; 837/2310B/NM1/82/02; institutional: 837/2420A/NM1/72/02; 837/2420C/NM1/82/02; 837/2310A/NM1/71/02	Service Provider Entity Type Qualifier	char	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 a "person", and these shall be coded as a person. Health care claims processors shall code according to:	TH
					1 Person	
					2 Non-Person Entity	
MC028	professional: 837/2420A/NM1/82/04; 837/2310B/NM1/82/04; institutional: 837/2420A/NM1/72/04;	Service Provider First Name	varchar	25	Individual first name. Set to null if provider is a facility or organization.	O

	837/2420C/NM1/82/04; 837/2310A/NM1/71/04					
MC029	professional: 837/2420A/NM1/82/05; 837/2310B/NM1/82/05; institutional: 837/2420A/NM1/72/05; 837/2420C/NM1/82/05; 837/2310A/NM1/71/05	Service Provider Middle Name	varchar	25	Individual middle name or initial. Set to null if provider is a facility or organization.	O
MC030	professional: 837/2420A/NM1/82/03; 837/2310B/NM1/82/03; institutional: 837/2420A/NM1/72/03; 837/2420C/NM1/82/03; 837/2310A/NM1/71/03	Service Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R

MC031	professional: 837/2420A/NM1/82/07; 837/2310B/NM1/82/07; institutional: 837/2420A/NM1/72/07; 837/2420C/NM1/82/07; 837/2310A/NM1/71/07	Service Provider Suffix	varchar	10	Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall 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, LCSW).	O
MC032	professional: 837/2420A/PRV/PE/03; 837/2310B/PRV/PE/03; institutional: 837/2310A/PRV/AT/03	Service Provider Specialty	varchar	10	As defined by payer. Dictionary for specialty code values must be supplied during testing.	R
MC108		Service Provider Street Address	Varchar	50	Physical practice location street address of the provider administering the services	R
MC033	professional: 837/2420C/N4/ /01; 837/2310C/N4/ /01; institutional: 837/2310E/N4/ /01	Service Provider City Name	varchar	30	City name of provider - preferably practice location	R
MC034	professional: 837/2420C/N4/ /02; 837/2310C/N4/ /02; institutional: 837/2310E/N4/ /02	Service Provider State or Province	char	2	As defined by the US Postal Service	R

MC035	professional: 837/2420C/N4/ /03; 837/2310C/N4/ /03; institutional: 837/2310E/N4/ /03	Service Provider ZIP Code	varchar	11	ZIP Code of provider - may include non-US codes; do not include dash. Plus 4 optional but desired.	R
MC036	837/2300/CLM/ /05-1	Type of Bill – Institutional	char	3	Required for institutional claims; Not to be used for professional claims	O (institutional claims only)
					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 Facilities (CORFs)	
					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	
					1 admit through discharge	
					2 interim - first claim used for the…	
					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	
MC037	837/2300/CLM/ /05-1	Facility Type - Professional	char	2	Required for professional claims. Not to be used for institutional claims. Map where you can and default to “99” for	O (professional claims only)

					all others.	
					11 Office	
					12 Home	
					21 Inpatient Hospital	
					22 Outpatient Hospital	
					23 Emergency Room - Hospital	
					24 Ambulatory Surgery Center	
					25 Birthing Center	
					26 Military Treatment Facility	
					31 Skilled Nursing Facility	
					32 Nursing Facility	
					33 Custodial Care Facility	
					34 Hospice	
					35 Boarding Home	
					41 Ambulance - Land	
					42 Ambulance - Air or Water	
					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	
					50 Federally Qualified Center	
					60 Mass Immunization Center	
					61 Comprehensive Inpatient Rehabilitation Facility	

					62 Comprehensive Outpatient Rehabilitation Facility	
					65 End Stage Renal Disease Treatment Facility	
					71 State or Local Public Health Clinic	
					72 Rural Health Clinic	
					81 Independent Laboratory	
					99 Other Unlisted Facility	
MC038	835/2100/CLP/ /02	Claim Status	char	2	See Lookup Table B-1.C	R
MC039	837/2300/HI/BJ/02-1-2	Admitting Diagnosis	varchar	7	Required on all inpatient admission claims and encounters. ICD-9-CM or ICD-10-CM. Do not code decimal point.	O (inpatient claims and encounters only)
MC898	N/A	ICD-9 / ICD-10 Flag	char	1	0 This claim contains ICD-9-CM codes 1 This claim contains ICD-10-CM codes The purpose of this field is to identify which code set is being utilized.	R
MC040	837/2300/HI/BN/03-1-2	E-Code	varchar	7	Describes an injury, poisoning or adverse effect. ICD-9-CM or ICD-10-CM. Do not code decimal point.	O
MC041	837/2300/HI/BK/01-2	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	R
MC042	837/2300/HI/BF/01-2	Other Diagnosis – 1	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC043	837/2300/HI/BF/02-2	Other Diagnosis – 2	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC044	837/2300/HI/BF/03-2	Other Diagnosis – 3	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC045	837/2300/HI/BF/04-2	Other Diagnosis – 4	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O

MC046	837/2300/HI/BF/05-2	Other Diagnosis – 5	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC047	837/2300/HI/BF/06-2	Other Diagnosis – 6	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC048	837/2300/HI/BF/07-2	Other Diagnosis – 7	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC049	837/2300/HI/BF/08-2	Other Diagnosis – 8	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC050	837/2300/HI/BF/09-2	Other Diagnosis – 9	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC051	837/2300/HI/BF/10-2	Other Diagnosis – 10	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC052	837/2300/HI/BF/11-2	Other Diagnosis – 11	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC053	837/2300/HI/BF/12-2	Other Diagnosis – 12	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC054	835/2110/SVC/NU/01-2	Revenue Code	char	10	National Uniform Billing Committee Codes. Code using leading zeroes, left justified, and four digits.	R
MC055	835/2110/SVC/HC/01-2	Procedure Code	varchar	10	Health Care Common Procedural Coding System (HCPCS); This includes the CPT codes of the American Medical Association.	R
MC056	835/2110/SVC/HC/01-3	Procedure Modifier – 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	O
MC057	835/2110/SVC/HC/01-4	Procedure Modifier – 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	O

MC058	835/2110/SVC/ID/01-2	ICD-9-CM Procedure Code	char	4	Primary procedure code for this line of service. Do not code decimal point.	R
MC059	835/2110/DTM/150/02	Date of Service – From	Date	8	First date of service for this service line. CCYYMMDD	R
MC060	835/2110/DTM/151/02	Date of Service – Thru	Date	8	Last date of service for this service line. CCYYMMDD	R
MC061	835/2110/SVC/ /05	Quantity	int	3	Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.	R
MC062	835/2110/SVC/ /02	Charge Amount	int	10	Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000 Same for all financial data that follows.	R
MC063	835/2110/SVC/ /03	Paid Amount	int	10	Includes any withhold amounts. Do not code decimal point. For capitated claims set to zero.	R
MC064	N/A	Prepaid Amount	int	10	For capitated services, the fee for service equivalent amount. Do not code decimal point.	R
MC065	N/A	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.	R
MC066	N/A	Coinsurance Amount	int	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.	R
MC067	N/A	Deductible Amount	int	10	Do not code decimal point.	R
MC068	837/2300/CLM/ /01	Patient	varchar	20	Number assigned by hospital	O

		Account/Control Number				
MC069	N/A	Discharge Date	Date	8	Date patient discharged. Required for all inpatient claims. CCYYMMDD	O (inpatient claims only)
MC070	N/A	Service Provider Country Name	varchar	30	Code US for United States.	R
MC071	837/2300/HI/DR/01-2	DRG	varchar	10	Insurers and health care claims processors 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 DRG system is used, the insurer 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).	O
MC072	N/A	DRG Version	char	2	Version number of the grouper used	O
MC073	835/2110/REF/APC/02	APC	char	4	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider.	O
MC074	N/A	APC Version	char	2	Version number of the grouper used	O
MC075	837/2410/LIN/N4/03	Drug Code	varchar	11	An NDC code used only when a medication is paid for as part of a medical claim.	O

MC076	837/2010AA/NM1/ID/09	Billing Provider Number	varchar	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.	TH
MC077	837/2010AA/NM1/XX/09	National Billing Provider ID	varchar	20	National Provider ID	TH
MC078	837/2010AA/NM1//03	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	TH
MC101	837/2010BA/NM1//03	Subscriber Last Name	varchar	128	Subscriber last name	R
MC102	837/2010BA/NM1//04	Subscriber First Name	varchar	128	Subscriber first name	R
MC103	837/2010BA/NM1//05	Subscriber Middle Initial	char	1	Subscriber middle initial	O
MC104	837/2010CA/NM1//03	Member Last Name	varchar	128		R
MC105	837/2010CA/NM1//04	Member First Name	varchar	128		R
MC106	837/2010CA/NM1//05	Member Middle Initial	char	1		q
MC899	N/A	Record Type	char	2	Value = MC	R

A-3 PHARMACY CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Payers submit data in a single, consistent format for each data type.

PHARMACY CLAIMS FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	PC
HD002	Payer Code	char	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	char	75	Example:
HD004	Beginning Month	Date	6	CCYYMM
HD005	Ending Month	Date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical claims file, excluding header and trailer records

PHARMACY CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	PC
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
TR003	Payer Name	varchar	75	
TR004	Beginning Month	Date	6	CCYYMM
TR005	Ending Month	Date	6	CCYYMM
TR006	Extraction Date	Date	8	CCYYMMDD

A-3.1 PHARMACY CLAIMS FILE

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC001	N/A	Payer	varchar	8	Payer submitting payments MHDO Submitter Code; MN has its own codes too	R
PC002	N/A	Plan ID	varchar	30	CMS National Plan ID or NAIC	R
PC003	N/A	Insurance Type/Product Code	char	2	See lookup table B-1.A	R
PC004	N/A	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system.	R

PC005	N/A	Line Counter	tinyint	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.	R
PC006	301-C1	Insured Group Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber	R
PC007	302-C2	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	TH
PC008	N/A	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
PC009	303-C3	Member Suffix or Sequence Number	varchar	20	Unique number of the member within the contract. Must be an identifier that is unique to the member.	R
PC010	302-C2	Member Identification Code	varchar	128	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	TH
PC011	306-C6	Individual Relationship Code	char	2	Member's relationship to insured See Lookup Table B-1.B	R
PC012	305-C5	Member Gender	char	1	1 – Male 2 – Female 3 - Unknown	R
PC013	304-C4	Member Date of Birth	Date	8	CCYYMMDD	R
PC014	N/A	Member City Name of Residence	varchar	50	City name of member	R

PC015	N/A	Member State or Province	char	2	As defined by the US Postal Service	R
PC016	N/A	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes; Do not include dash. Plus 4 optional but desired.	R
PC017	N/A	Date Service Approved (AP Date)	Date	8	CCYYMMDD – date claim paid if available, otherwise set to Date Prescription Filled	O
PC018	201-B1	Pharmacy Number	varchar	30	Payer assigned pharmacy number. AHFS number is acceptable.	O
PC019	N/A	Pharmacy Tax ID Number	varchar	10	Federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBM's will not have this)	TH
PC020	833-5P	Pharmacy Name	varchar	50	Name of pharmacy	R
PC021	N/A	National Provider ID Number	varchar	20	National Provider ID. This data element pertains to the entity or individual directly providing the service.	O
PC048	N/A	Pharmacy Location Street Address	Varchar	30	Street address of pharmacy	
PC022	831-5N	Pharmacy Location City	varchar	30	City name of pharmacy - preferably pharmacy location (if mail order null)	R
PC023	832-5O	Pharmacy Location State	char	2	As defined by the US Postal Service (if mail order null)	R
PC024	835-5R	Pharmacy ZIP Code	varchar	10	ZIP Code of pharmacy - may include non-US codes. Do not include dash. Plus 4 optional but desired (if mail order null)	R
PC024A	N/A	Pharmacy Country Name	varchar	30	Code US for United States	R
PC025	N/A	Claim Status	char	2	See Lookup Table B-1.C.	O
PC026	407-D7	Drug Code	varchar	11	NDC Code	R

PC027	516-FG	Drug Name	varchar	80	Text name of drug	R
PC028	403-D3	New Prescription or Refill	varchar	2	Older systems provide only an “N” for new or an “R” for refill, otherwise provide refill #	R
					01 - New prescription	
					02 - Refill	
PC029	425-DP	Generic Drug Indicator	char	2		R
					01 - branded drug	
					02 - generic drug	
PC030	408-D8	Dispense as Written Code	char	1	Payers able to map available codes to those below	R
					0 Not dispensed as written	
					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	406-D6	Compound Drug Indicator	char	1		O
					N Non-compound drug	
					Y Compound drug	
					U Non-specified drug compound	
PC032	401-D1	Date Prescription Filled	Date	8	CCYYMMDD	R
PC033	404-D4	Quantity Dispensed	int	5	Number of metric units of medication dispensed	O

PC034	405-D5	Days Supply	int	3	Estimated number of days the prescription will last	O
PC035	804-5B	Charge Amount	int	10	Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000 Same for all financial data that follows.	R
PC036	876-4B	Paid Amount	int	10	Includes all health plan payments and excludes all member payments. Do not code decimal point.	R
PC037	506-F6	Ingredient Cost/List Price	int	10	Cost of the drug dispensed. Do not code decimal point.	R
PC038	428-DS	Postage Amount Claimed	int	10	Do not code decimal point. Not typically captured.	O
PC039	412-DC	Dispensing Fee	int	10	Do not code decimal point.	R
PC040	817-5E	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.	R
PC041	N/A	Coinsurance Amount	int	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.	R
PC042	N/A	Deductible Amount	int	10	Do not code decimal point.	R
PC043	N/A	Unassigned			Reserved for assignment	O
PC044	N/A	Prescribing Physician First Name	varchar	25	Physician first name.	O if PC047 is filled with DEA #
PC045	N/A	Prescribing Physician Middle Name	varchar	25	Physician middle name or initial.	O if PC047 is filled with

						DEA #
PC046	427-DR	Prescribing Physician Last Name	varchar	60	Physician last name.	O if PC047 is filled with DEA #; R if PC047 is not filled or contains NPI number
PC047	421-DZ	Prescribing Physician Number	varchar	20	DEA or NPI number for prescribing physician	O
PC049		Member Street Address	varchar	50	Street address of member	R
PC101	313-CD	Subscriber Last Name	varchar	128		R
PC102	312-CC	Subscriber First Name	varchar	128		R
PC103	N/A	Subscriber Middle Initial	char	1		O
PC104	311-CB	Member Last Name	varchar	128		R
PC105	310-CA	Member First Name	varchar	128		R
PC106	N/A	Member Middle Initial	char	1		O
PC899	N/A	Record Type	char	2	PC	R

A-4 PROVIDER DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Payers submit data in a single, consistent format for each data type.
- A provider means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.
- A billing provider means a provider or other entity that submits claims to health care claims processors for health care services directly performed or provided to a subscriber or member by a service provider.
- A service provider means the provider who directly performed or provided a health care service to a subscriber of member.
- One record submitted for each provider for each unique physical address.

PROVIDER FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	MP
HD002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	varchar	75	
HD004	Beginning Month	Date	6	CCYYMM (Example: 200801)
HD005	Ending Month	Date	6	CCYYMM (Example: 200812)
HD006	Record count	int	10	Total number of records submitted in the medical eligibility file, excluding header and trailer records

PROVIDER FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	MP
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable

TR003	Payer Name	varchar	75	
TR004	Beginning Month	Date	6	CCYYMM (Example: 200801)
TR005	Ending Month	Date	6	CCYYMM (Example: 200812)
TR006	Extraction Date	Date	8	CCYYMMDD

A-4.1 PROVIDER FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MP001	N/A	Provider ID	varchar	30	Unique identified for the provider as assigned by the reporting entity	R
MP002	N/A	Provider Tax ID	varchar	10	Tax ID of the provider. Do not code punctuation.	R
MP003	N/A	Provider Entity	char	1	F – Facility G – Provider I – IPA P - Practitioner	R
MP004	N/A	Provider First Name	varchar	25	Individual first name. Set to null if provider is a facility or organization.	R
MP005	N/A	Provider Middle Name or Initial	varchar	25		O
PM006	N/A	Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R
MP007	N/A	Provider Suffix	varchar	10	Example: Jr;null if provider is an organization. Do not use credentials such as MD or PhD	O
MP008	N/A	Provider Specialty	varchar	50	Report the HIPAA-compliant health care provider taxonomy code. Code set is freely available at the National Uniform Claims Committee's web site	R

					http://www.nucc.org/	
MP009	N/A	Provider Office Street Address	varchar	50	Physical address – address where provider delivers health care services	R
MP010	N/A	Provider Office City	varchar	30	Physical address – address where provider delivers health care services	R
MP011	N/A	Provider Office State	char	2	Physical address – address where provider delivers health care services. Use postal service standard 2 letter abbreviations.	R
MP012	N/A	Provider Office Zip	varchar	11	Physical address – address where provider delivers health care services. Minimum 5 digit code.	R
MP013	N/A	Provider DEA Number	varchar	12		TH
MP014	N/A	Provider NPI	varchar	20		TH
MP015	N/A	Provider State License Number	varchar	15	Prefix with two-character state of licensure with no punctuation. Example COLL12345	TH
MP899	N/A	Record Type	char	2	MP	R

B-1 LOOKUP TABLES

B-1.A INSURANCE TYPE

12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
15 Indemnity Insurance
16 Health Maintenance Organization (HMO) Medicare Advantage
CI Commercial Insurance Company
HM Health Maintenance Organization
HN HMO Medicare Risk/ Medicare Part C
MA Medicare Part A
MB Medicare Part B
MC Medicaid
MD Medicare Part D
MP Medicare Primary
QM Qualified Medicare Beneficiary
SP Supplemental Policy
TV Title V
99 Other

B-1.B RELATIONSHIP CODES

01 Spouse
04 Grandfather or Grandmother
05 Grandson or Granddaughter
07 Nephew or Niece
10 Foster Child
15 Ward
17 Stepson or Stepdaughter
19 Child
20 Employee/Self
21 Unknown
22 Handicapped Dependent
23 Sponsored Dependent
24 Dependent of a Minor Dependent
29 Significant Other
32 Mother
33 Father
36 Emancipated Minor
39 Organ Donor
40 Cadaver Donor
41 Injured Plaintiff
43 Child Where Insured Has No Financial Responsibility
53 Life Partner
76 Dependent

B-1.C CLAIM STATUS

01 Processed as primary
02 Processed as secondary
03 Processed as tertiary
19 Processed as primary, forwarded to additional payer(s)
20 Processed as secondary, forwarded to additional payer(s)
21 Processed as tertiary, forwarded to additional payer(s)
22 Reversal of previous payment