New Hampshire Comprehensive Health Care Information System (NH CHIS)

Data Submission Manual

Effective: 02/01/2021

New Hampshire CHIS comprehensive health care information system

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Introduction

The New Hampshire Comprehensive Health Care Information System (CHIS) was created by NH 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 which 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.

Regulatory Authority

Claims data must be submitted in accordance with the requirements as specified in this Data Submission Manual, which have been derived from the New Hampshire Insurance Department (NHID) rules, *Chapter Ins 4000 Uniform Reporting System for Health Care Claims Data Sets*. The New Hampshire *Chapter Ins 4000* rules can be accessed at: http://gencourt.state.nh.us/rules/state_agencies/ins4000.html.

Upon any future amendment to Chapter Ins 4000, carriers and third-party administrators shall be required to submit data that conform to the updated specifications no later than 180 days after the effective date of the new version of the rule.

Vendor Agreement

After a competitive bid process, in June of 2012 NH DHHS, Office of Medicaid Business and Policy, contracted with Milliman to assume maintenance of the CHIS. Under the contract, Milliman is acting as DHHS's agent for the collection of claims data, and is providing a series of reports and studies for DHHS that examine the NH Medicaid program in concert with using the commercial data for benchmarking, and is hosting this website. Milliman is strictly prohibited from collecting any un-hashed social security numbers or other direct identifiers and from releasing or using data or information obtained in its capacity as a collector and processor of the data for any purposes other than those specifically authorized by the agreement. The agreement provides that Milliman shall transmit all data that it collects and processes to the NHID and the NH DHHS.

Contact Information

Questions related to the NH CHIS program, the Chapter Ins 4000 rules, or other requirements requiring a decision from the State of New Hampshire are be addressed to:

NHID	Maureen.A.Mustard@ins.nh.gov
NH DHHS	Mary.Fields@dhhs.state.nh.us

For any questions regarding the transmission of data to Milliman for the purposes of the CHIS, please send an email to: NHCHISsupport@milliman.com.

General Submission Requirements

Employees/Members Included

State of New Hampshire statutes and rules mandate that all health insurance carriers and third party administrators submit electronic claims data for all residents of New Hampshire and for all members who receive services under a policy issued in New Hampshire, as follows:

1. Any policy that provides coverage to the employees of a New Hampshire employer that has a business location in New Hampshire shall be considered a policy that is issued in New Hampshire;

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

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

De Minimus Thresholds

Carriers and third-party administrators shall not be required to submit health care claims data files if they meet the following criteria:

1. For carriers that do not offer any products on the health insurance exchange for residents of New Hampshire, and that did not cover more than 9,999 members in New Hampshire at any point in any medical, pharmacy or dental coverage class during the prior calendar year; or

2. For third-party administrators that did not cover more than 9,999 members in New Hampshire at any point in any medical, pharmacy or dental coverage class during the prior calendar year.

The 9,999 member calculation for both carriers and third-party administrators shall be made at the corporate entity level and shall be an aggregate of all units or separate corporate divisions operating under the corporate entity. If the unit or corporate division has an exceptionally small number of members, or other extenuating circumstances exist that would cause undue hardship to include the unit or division in the calculations and data submissions, a carrier or third-party administrator may request an exception from the NHID and NH DHHS.

Carriers or third-party administrators experiencing a drop in membership below the de minimis threshold shall submit claims data and any corrections to membership files for a period of 180 days from the point the carrier or third-party administrator meets the de minimis exemption.

Coverage Type Exclusions

Carriers and third-party administrators shall not be required to submit health care claims data about coverage that is not part of a comprehensive medical insurance policy, including the following: (1) Specific disease; (2) Accident; (3) Injury; (4) Hospital indemnity; (5) Disability; (6) Long-term care; (7) Vision coverage; (8) Durable medical equipment; or (9) Blanket health insurance. Claims for these types of coverage shall be included in the medical claims file submission if they are part of a comprehensive medical insurance policy.

Carve Out Requirements

When more than one entity is involved in the administration of a policy, data shall be submitted in accordance with the following:

1. A carrier shall be responsible for submitting the claims data on policies that it has written;

2. A third-party administrator shall be responsible for submitting claims data on self-insured plans that it administers;

3. Each carrier and third-party administrator shall submit all health care claims processed by any subcontractor on its behalf, including but not limited to claims related to pharmacy services, dental services, and behavioral health, mental health and substance abuse treatment services;

4. Each carrier and third-party administrator shall ensure that the subcontractor is not submitting duplicate claims to the department or its designee if the subcontractor falls under the definition of a carrier, meets the requirements of this section, and is required to submit data as a separate entity; and

5. Each carrier and third-party administrator shall ensure that member and subscriber identifiers in any files processed by subcontracts are consistent with member and subscriber identifiers in the medical and pharmacy claims files and the member eligibility files.

Overview of the Data Submission Process

This document provides a detailed explanation of the process and data requirements for submitting Member, claims, and provider files to Milliman for the CHIS program.

Carriers and third-party administrators required to submit data to the NH CHIS must conform to the following process:

1. Complete and submit the on-line registration form.

2. Generate data extracts including all required data elements and formats in accordance with the specifications and requirements set forth in this Data Submission Manual.

3. Process extracts through the NHpreprocessor. This application and the associated user guide will be provided via email upon completion and submission of the registration form. Assistance with the NHpreprocessor application is provided at: NHCHISsupport@milliman.com.

4. Submit data processed through the preprocessing application to Milliman, preferably through the secure file transfer server using your SFTP account. This account will be emailed to you when you complete the registration form. If you need assistance, please send an email to: NHCHISsupport@milliman.com. Alternative methods for submitting data are also provided in the "Submitting Data Using the NHpreprocessor" section of this document.

5. Milliman will conduct field file and data quality checks on the submitted data and complete the processing for loading into the NH CHIS data warehouse. If any issues arise with the submitted data during the processing or integration into the data warehouse, Milliman will email a detailed summary of problems to be addressed to the carrier or third-party administrator.

6. If issues with data quality cannot be rectified and the files resubmitted, carriers and third-party administrators may request from the State of New Hampshire long term or temporary exceptions for data elements not meeting established default threshold levels.

Registration

General Requirements

Each carrier and third-party administrator meeting NH's health care claims data submission requirements must register with Milliman prior to submitting any data files and must abide by the following requirements:

1. A completed/updated NHCHIS registration form must be submitted to Milliman by March 15 of every calendar year;
2. Notification via email shall be given to Milliman within 30 days of changes to any of the annual NHCHIS registration information;
3. Notification via email shall be given to Milliman of any changes to the individual contact information submitted on the NHCHIS registration form as soon as possible, but no later than 30 days after a reassignment occurs; and
4. The NHCHIS registration form is to be submitted through the NHCHIS website.

To register or re-register online, please use the following link: https://nhchis.com/Registration/Company.

Registration Form Content

The NHCHIS registration form for carriers and third-party administrators shall contain, at a minimum, the following fields:

1. Company Name;
2. Corporate NAIC Code;
3. Company Name Mailing Address;
4. Company Name City;
5. Company Name State;
6. Company Name Zip;
7. Submitter Last Name, First Name;
8. Submitter Email;
9. Submitter Phone;
10. Date Required to Submit Data;
11. Compliance/Government Affairs Last Name, First Name;
12. Compliance/Government Affairs Email;
13. Compliance/Government Affairs Phone;
14. Alternate Contact 1 Last Name, First Name;

15. Alternate Contact 1 Office and Title;
16. Alternate Contact 1 Email;
17. Alternate Contact 1 Phone;
18. Alternate Contact 2 Last Name, First Name;
19. Alternate Contact 2 Office and Title;
20. Alternate Contact 2 Email;
21. Alternate Contact 2 Phone;
22. Line of Business: Comprehensive Medical/Medicare Supplemental/Dental only/Pharmacy;
23. Health Insurance In-State (Y/N);
24. Month Registration Form Created/Amended: MMYY;
25. Estimated Number of Covered Lives Per Month;
26. Estimated Number of Medicare Supplemental Covered Lives Per Month;
27. Data File Type;
28. Payer Code;
29. Sub-Company/Separate Submission Platforms;
30. Submitter Receives: Newsletters, SFTP Account Information, Access to the Report Portal;
31. Compliance/Government Affairs Receives: Data Submission Notifications, Data Submission Reports, Newsletters, SFTP Account Information, Access to the Report Portal;
32. Alternate Contact 1 Receives: Data Submission Notifications, Data Submission Reports, Newsletters, SFTP Account Information, Access to the Report Portal;
33. Alternate Contact 2 Receives: Data Submission Notifications, Data Submission Reports, Newsletters, SFTP Account Information, Access to the Report Portal;
34. Parent Company NAIC Code and Name; and
35. Data Platform Information.

Data Filing Requirements

Filing Schedules

Carriers and third-party administrators that have 10,000 or more New Hampshire members and carriers that offer products on the health insurance exchange shall submit required NHCHIS files monthly, no later than 30 calendar days after the close of the reporting month.

First-Time Filers

Carriers and third-party administrators that have not previously submitted files to the department or its designee and that have never registered shall register no later than 30 days after the first applicable requirement to submit data, using the NHCHIS registration form. First time submitters shall provide test files within 120 days after registration. The test file shall include all required files containing paid claim dates for the most recent complete month.

No later than 150 days after registration, newly-submitting carriers and third-party administrators shall submit files containing the 3 most recent calendar years of data, January through December. Year-to-date information and monthly files shall be provided no later than 180 days after registration.

Modifications to Submission Process, Format, or Source

Carriers and third-party administrators that change health plan identifiers or implement new data submission platforms through acquisitions, mergers, or reorganization 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 systems shall provide additional documentation pursuant to instructions from Milliman to ensure that NHCHIS maintains a continuous record of member enrollment and claims history before and after the changes.

Observation Period for Record Selection

Carriers and third-party administrators shall submit a member 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 and for one or more dates of coverage for the prior two months. It shall include benefits, attributes, and associated effective periods. Carriers and third-party administrators shall include all claims adjudicated during the reporting month for all members in the member file for that month. Carriers' and third-party administrators' data submissions shall contain 180 days of claims run out for members in all current or previously submitted files.

Submitting Data Using the NHpreprocessor

Introduction

Carriers and third-party administrators must use the File Submission "Preprocessor" (NHpreprocessor) provided by Milliman. The NHpreprocessor is used to hash ASCII files that contain health care claims data that will be submitted to the state of New Hampshire CHIS. The utility hashes the specified ASCII files, creating an output ASCII file and a zip file. Non-ASCII files are not supported. The NHpreprocessor also hashes (de-identifies) all member and subscriber identification codes and names before the data leaves the carrier's and third-party administrator's system are transmitted to Milliman. To ensure consistent hashing, subscriber and member identifiers should not be encrypted or hashed on the initial extract loaded into the preprocessor.

Milliman will provide the most current version of the NHpreprocessor application as a down load through a password protected portal to all registered carriers and third-party administrators. A user guide will also be provided. If you have completed and submitted the on-line registration form and have not received the application, please send a request to: NHCHISsupport@milliman.com.

The user guide will be sent with the application, but the contents of the user guide have also been included here.

System Requirements

This application runs on the following 64-bit versions of the Windows operating systems:

- Windows Server 2016
- Windows Server 2012 R2
- Windows 10

In addition, the above operating systems, the MedInsight NHpreprocessor application also supports the Linux operating system (Ubuntu 18.04) (Console mode only). Regardless of the system being used, the most recent service pack must be installed. The application requires the system to have Microsoft .NET Core 3.1 **Desktop** runtime installed**.**

Installation Instructions

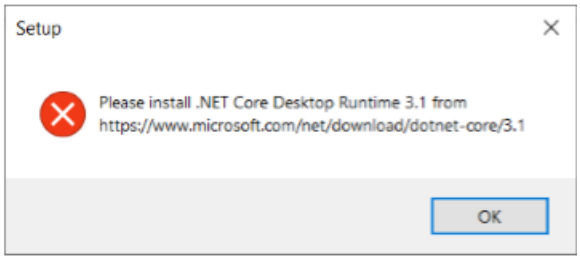
The user must run the setup program using an account that has local administrator rights. Medinsight NH preprocessor 3.0 will require the .NET Core 3.1 **desktop** runtime to be installed on the system. To install the application, follow these steps:

1. Copy the NHpreprocessor setup program to a local drive.

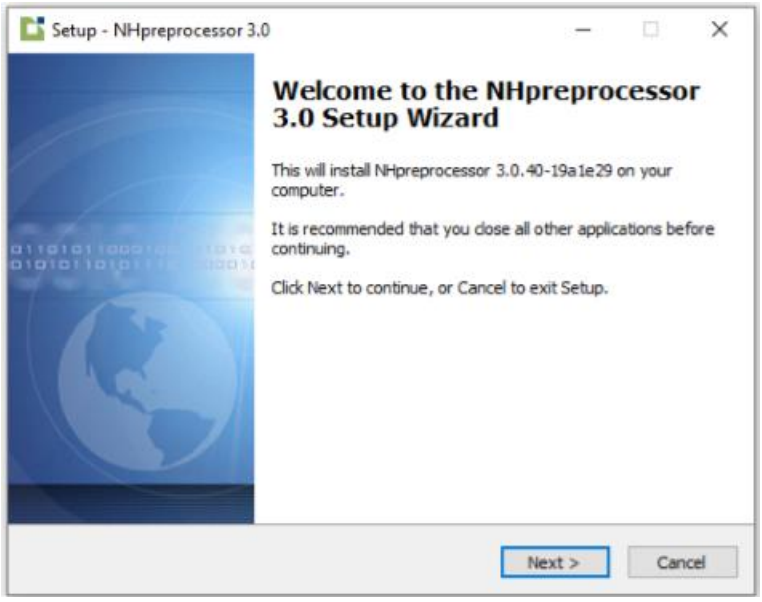
2. Right-click on the program, waiting for the context-menu to appear.

3. Launch the program with “Run-As-Administrator” rights.

4. The setup program will verify that Microsoft .NET Core 3.1 **desktop** runtime is installed. If it’s not installed, the setup program will abort the installation process and will ask to install it. In this case, the setup program will show the link from where the .NET Core 3.1 desktop runtime can be downloaded.



5. The setup program will present the “Welcome to NHpreprocessor 3.0 Setup Wizard” screen. Click on the “Next” command button.



6. The setup program will ask for the location where the application should be installed. If the default path is not acceptable, update the default path by clicking on the “Browse” command button. Once you have updated the path, click on the “Next” command button.

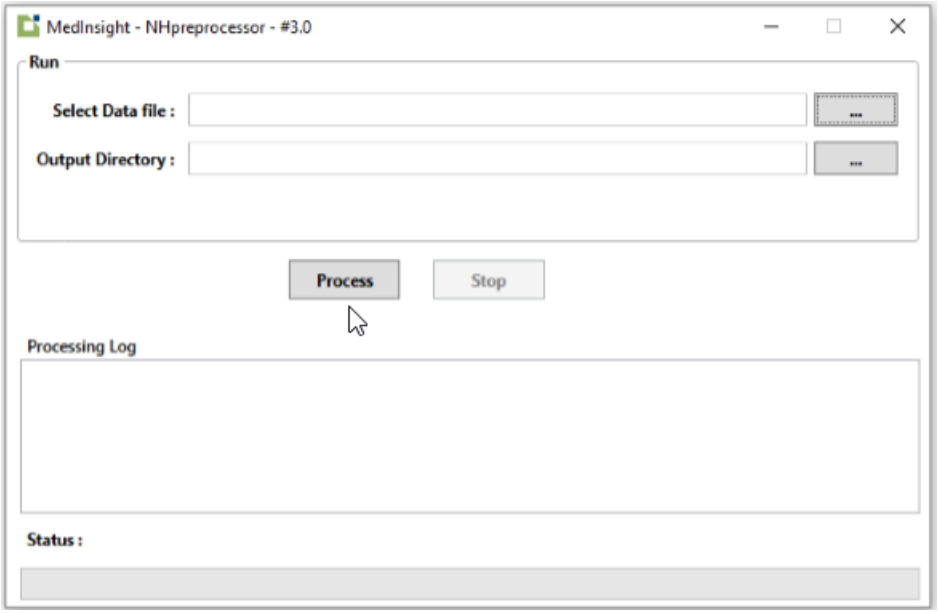
7. The setup program is now ready to install. Click “Install” to continue with the installation or click “Back” if you want to review or change any setting. To begin the installation process, click the “Install” button.

8. The setup program will then complete the installation process. When it completes, the setup program may or may not prompt the user to restart the computer now or later. Select the appropriate time and click on the “Finish” command button.

The installation process is now complete. The user can verify if the program installed successfully by launching the application, and then processing the sample files that come with it. User can start the application from Start → Milliman → NHpreprocessor 3.0.

Using the NHpreprocessor

The user may run the client utility using an account that has standard user rights. The program may be launched by clicking on Start-> Milliman -> NHpreprocessor 3.0. Once the utility has been launched, the user is presented with the following form: Click on the “Select File to Be Encrypted” command button to specify the input file.

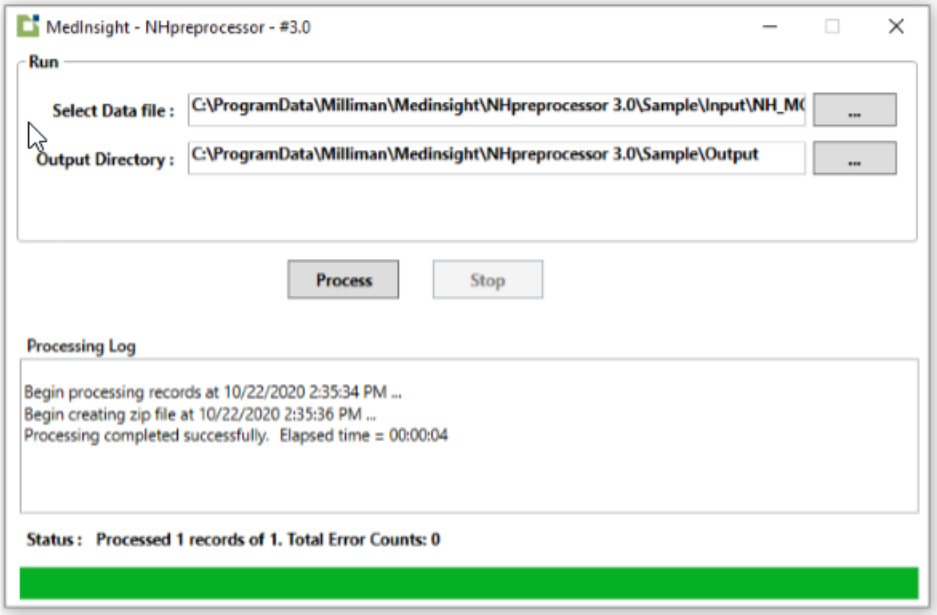


1. Click on the button next to “Select Data file” text box to specify the input file.

2. Click on the button next to “Output Directory” text box to specify the folder where the output file and log file will be created. Note that the utility will fail if the user does not have modify rights on the folder selected.

3. Click on the “Process” button to process the file.

4. When the utility successfully processes the file and creates the zip file, it presents the user with the dialogue box shown below.



5. The utility names the output files using the following naming convention: FileTypeProjectNaicBegin_End Version (e.g., MCNHABCDEVGH201201_2015061003.txt). Data files are given a .txt extension and zip files are given a .zip extension.

Element	Contents	Length
FILETYPE	ME, MC, PC, DC. MP	char(2)
PROJECT	NH	char(2)
NAIC	Alphanumeric, currently up to 8 characters long.	varchar(8)
PERIODBEGIN	YYYYMM	char(6)
PERIODEND	YYYYMM	char(6)
VERSION	Version of the utility used to create the file.	varchar(8)

Using the Batch Utility

If the user wants to automate the creation of the output file and zip file, the user may run the batch utility NHpreprocessbatch.dll. The user may run the utility using an account that has standard user rights. The utility returns 0 if it completes the encryption process successfully. Otherwise, it returns a non-zero value.

Note: If there is any error during processing, the user will get an error prompt on the user interface and in case of batch run it will give a nonzero exit code and all the output files for the current run will be deleted. A log file will be generated under the "LogFiles" folder, providing detailed information about the error. Also, if the output files are greater than 2 GB in size, application may

throw an error while zipping the output files. In this case, user needs to zip the output files manually.

Please review the Preprocessor User Guide found at the installation folder, for instructions how to execute the Batch Utility for Windows OS and Linux computers.

Trouble Shooting

The client utility presents the user with an “Error Processing File” dialogue box if the data in the file fails one or more data checks. The information presented in the dialogue box can be used to trouble shoot the data issue. Also the client utility and the batch utility create a log file with each run, which is stored in the output folder specified by the user. The log file contains additional information that may be useful in trouble shooting data issues.

Production Support

For support, please email NHCHISsupport@milliman.com.

Directions for Submitting Data

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

Electronic Transmission through a File-Transfer Program

Secure File Transport Protocol (SFTP) is the preferred method for submitting files. 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.

Accessing MedInsight Secure Transfer Server via FTP Client

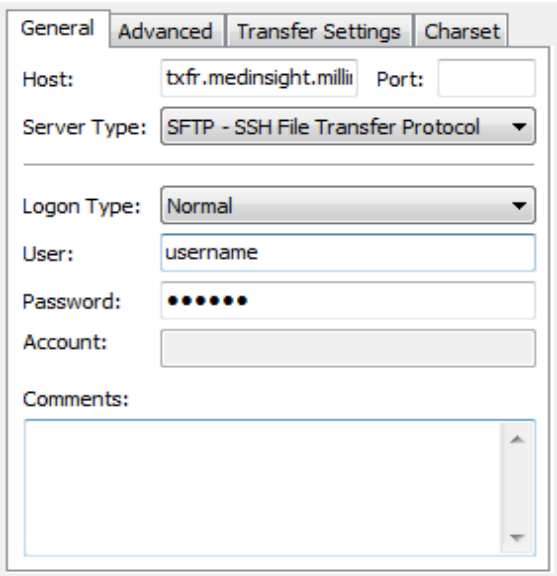
This method requires logging on to the appropriate FTP site and sending or receiving files using an SFTP client server. This may be desirable in cases where transfers need to be automated or when more flow control is needed (such as the ability to resume a transfer if it failed for some reason). Additionally, transfer speeds are generally better when using a client.

All registered carriers and third-party administrators will receive a letter from Milliman with their username. Passwords will be provided in a separate communication.

There are many different FTP clients available that support SFTP. FileZilla is one example and it is free. Below are the settings for configuring an FTP client for SFTP transfers:

Below are the settings for configuring an FTP client for SFTP transfers:

Host/Address: txfr.medinsight.milliman.com
Port: 22
Type: SFTP – SSH File Transfer Protocol
Logon Type: Normal



Secure SSL Web Upload Interface

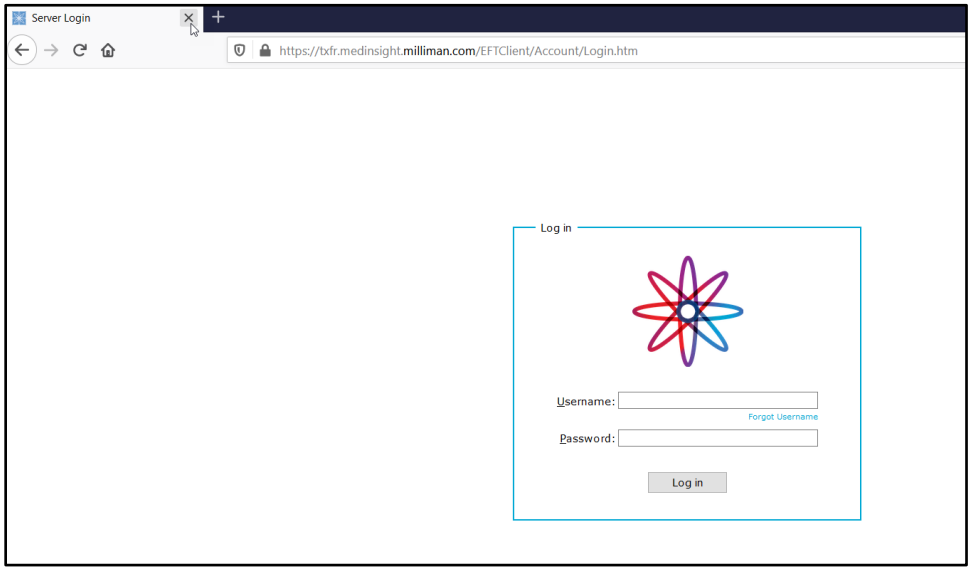
This method requires internet access, a username, and password. It is not the preferred method due to limitations on the size of the files that can be received, but can be utilized if it is the only method available.

Accessing MedInsight Secure Transfer Server via Internet Browser

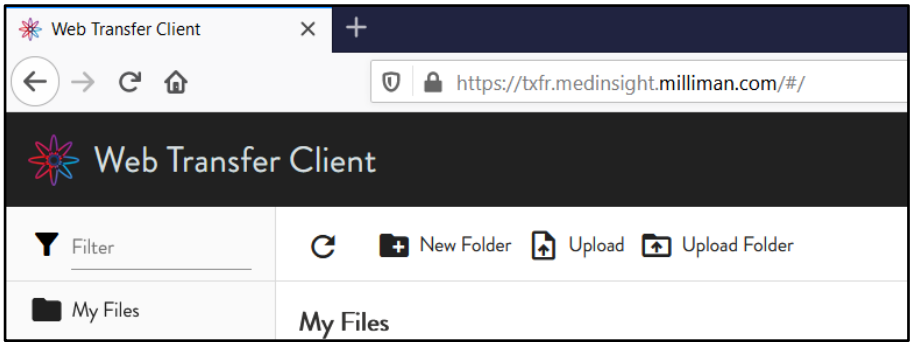
All registered carriers and third party administrators will receive a letter from Milliman with their username. Passwords will be provided in a separate communication.

Most browsers are supported, including Internet Explorer, Firefox, Chrome and Edge.

From an Internet browser, navigate to the address https://txfr.medinsight.milliman.com/EFTClient/Account/Login.htm and log in with your username and password:



Once logged in, you will be within your home directory. You can either stay there or navigate to other directories (if available). To transfer (download) files from the server to your local computer, simply find and double-click the file you would like to transfer. You can also multi-select files by holding the CTRL button and selecting files individually, or holding SHIFT and clicking on the first and last file you would like to transfer. To transfer (upload) files to the server, click the Upload button at the top of the page and click Browse, find the file you would like to upload, click OK and then click the Upload button:



Testing of Files

At least 30 days prior to the initial submission of the files, or whenever the data element content of the files is subsequently altered (e.g. – submission of data not previously available), each carrier or health care claims processor must submit to Milliman a data set for comparison to the same validation process used for actual submissions to determine if the data files are in compliance with the submission standards. A data set for 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.

Healthcare claims processors using non-conforming local/homegrown CPT and/or diagnosis codes must submit those codes with descriptions in MS Excel format prior to the first data submission. E-mail to: NHCHISsupport@milliman.com.

Compliance with Data Standards

Compliance

Carriers and third-party administrators shall submit files that conform to the formats, standards, and detailed file requirements in this data submission manual. Each member file, medical, pharmacy, dental claims file, and provider file submitted must conform to the following data reporting requirements**:**

1. The applicable code for each data element shall be included within the eligible values for the element;

2. Coding values indicating “data not available”, “data unknown”, or the equivalent shall not be used for individual data elements unless specified as an eligible value for the element;

3. Member date of birth, gender, diagnosis and procedure codes, and all other data fields shall be consistent within an individual record; and

4. Member identifiers shall be consistent across files.

When registering, carriers and third-party administrators shall submit tables and descriptions for all nonconforming and plan-specific codes contained in the submission. Files with nonconforming and plan-specific codes without such explanatory information shall be rejected.

Validation and Auditing

After the files are loaded, Milliman will employ an automated validation process, File Field and Quality Checks (FFQC), to ensure that the format and content of each submitted file is valid and complete, with results being generated within 48 hours. Load threshold levels for individual data elements submitted are validated against those pre-established levels defined by NH DHHS and NHID.

The FFQC process is composed of two groups of audits: field level audits and quality audits:

1. 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 compared to pre-determined default percentages.

2. 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) and usually involve multiple data elements. Default thresholds (which can be rates or ranges) have been established for approximately 200 quality audits.

After the data files pass the FFQC process and are loaded into staging tables, additional reasonableness, longitudinal, and relational audits are run on the consolidated data to identify any global issues that would not be evident during the FFQC 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 and volume reconciliation.

A listing of all updated file field level and quality checks, with corresponding default load thresholds, is found within a separate document, entitled *NHCHIS File, Field, and Quality Checks (FFQC) User Guide.* The revised guide will be provided by Milliman to all carriers and third-party administrators and will be available on the NH CHIS website.

Notification / Data Submission Status

Within five days of submittal of the data files, Milliman will provide via email each carrier or third-party administrator with a report that provides detailed results of the validation process. The report will indicate which files have passed and which files have failed. If a file has failed, the report will also indicate the specific data element(s) that caused the failure.

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). The carrier or third-party administrator may correct and resubmit the files, request an element level exception through the FFQC process, or may submit a corrective action plan that the NH DHHS and NHID will review and accept or reject.

Resubmissions

If the problems can be rectified, the rejected and returned files are to be resubmitted in the appropriate, corrected form within 10 days. 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. Partial replacement files or record specific corrections will not be accepted.

Exceptions

The carrier or third-party administrator may request an element level exemption through the FFQC process to adjust the threshold for the failing field(s) due to the data being excluded from the claims transaction process.

Default thresholds (or rates) will be applied to the field level checks for each element in the member, claims files, and provider file, and for each quality check. The standard acceptable threshold for field length, field type, and data value audits is 100%. However, a number of fields will contain acceptable thresholds for data value at less than 100%. The default thresholds for the quality checks are dependent upon the specific set of fields involved and the logic being employed 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 check default thresholds, the carrier or third-party administrator can request an exemption to the default threshold through a standardized, automated process contained within the FFQC system. All exception requests must be approved by the NH DHHS and NHID.

Note: If exceptions were approved for specific data elements on your previous data submission by the NH DHHS and NHID, those exceptions will continue to be approved unless otherwise informed.

Waivers

Carrier or third-party administrators may submit a corrective action plan to the NH DHHS and NHID requesting temporary or long term waivers to the reporting requirements. NH DHHS and NHID may grant a waiver if a determination is made that the deficiencies will be removed in a reasonable period of time or, if the request is to eliminate the data submission requirement for a particular data element required under these rules, the carrier or third-party administrator must demonstrate that:

1. The data element does not exist on the carrier's or third-party administrator's transaction system;

2. The data element cannot be derived reliably from other information available on the carrier's or third-party administrator's transaction system; and

3. The data element does not reflect information necessary to process claims or to conduct business operations in accordance with generally accepted industry standards, such that it should reasonably be available.

A carrier or third-party administrator that has been granted a waiver shall populate that data field in its claims data submissions in the manner specified in the waiver.

Replacement of Data Files

No carrier or health care claims processor shall replace a complete data file submission more than one year after the end of the month in which the file was submitted unless it can establish exceptional circumstances for the replacement. Any replacements after this period shall be approved by the NH DHS and NHID. Individual adjustment records shall be submitted with a monthly data file submission.

General Data Requirements

Carriers and third-party administrators shall comply with the technical specifications and requirements (files, elements, formats, definitions, codes) contained in this data submission manual.

Included Records and Data Requirements

Carriers and third-party administrators are responsible for submitting the files in the following manner:

1. Records for the member file submission shall be reported at the individual member level so that:

    a. If a member is covered as both a subscriber and a dependent on 2 different policies during the same month, 2 records shall be submitted; and

    b. If a member has 2 contract numbers for 2 different coverage types, 2 member eligibility records shall be submitted.

2. Members without medical, pharmacy and/or dental coverage during the month reported shall be excluded from the member file.

3. If retroactive changes or updates occur which impact member eligibility, carriers and third party administrators shall submit a member file that contains data for each member eligible for medical, dental or pharmacy benefits for three months prior to the current reporting month. Any retrospective updates should correspond to previously submitted eligibility data.

4. Records for medical, pharmacy, and dental claims file submissions shall be reported at the visit, service, or prescription level and based upon the paid dates and not upon the dates of service associated with the claims.

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

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

7. Records for services provided under alternative payment arrangements with zero paid amounts shall be included in all medical, dental and pharmacy claims file submissions.

8. All service lines associated with fully-processed claims that have gone through an accounts payable run and have been booked to the health plan ledger shall be included in all medical, dental and pharmacy claims file submissions.

9. All claims related to behavioral or mental health shall be included in the medical claims file.

10. Claims for pharmacy services claims generated from non-retail pharmacies that do not contain national drug codes shall be included in the following files:

    a. If the pharmacy claims are covered under the medical benefit, the claims shall be included in the medical claims file and not the pharmacy claims file.

    b. If the claims are covered under a prescription benefit, the claims shall be included in the pharmacy claims file.

    c. If the claims are submitted as standard UB04, NSF, or ANSI 935 formatted transactions without NDC codes, the claims shall be included in the medical claims file.

Data Specifications

Claims data files are to be submitted in accordance with the following specifications:

1. Code sources:

    a. Carriers and third-party administrators shall use the values in the data tables found in this manual or the corresponding externally maintained code tables referenced herein.

    b. If externally mandated code tables are revised by the code source, whether the revision includes new codes or a modification of descriptions, the changes provided by the source preempt the definitions and descriptors provided in this manual.

    c. Carriers and third-party administrators shall submit tables and descriptions for all non-conforming and plan-specific codes contained in the submission. Milliman shall reject files with non-conforming and plan-specific codes if explanatory information is not provided in advance of the data submission.

2. 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.

3. 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, PC902, DC207) so that the latest version of that service line is the record with the highest version number (MC005A, PC902, DC207) 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 both the Pharmacy and Dental claims file.

4. Fully-processed service lines. All service lines associated with fully-processed claims that have gone through an accounts payable run and been booked to the health plan ledger shall be included on medical, pharmacy, and dental claims data submissions. Do not include service lines:

    a. Rejected due to failed edits;

    b. That are duplicates; or

    c. That are from an inactive member.

    d. Voided at the point of sale

5. 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, with:

    a. Each version of a claim service line enumerated sequentially with a higher line version number (MC005A, PC902, DC207); and

    b. Reversal versions of a claim service line indicated by a claim status code = '22' (Field MC038).for capitated services reported with all medical and pharmacy file submissions.

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

7. Global payment arrangements. If a claim contains service lines that do not contain a payment because their costs are covered on another line of the claim line, such as under a global payment arrangement, those line(s) shall be:

    a. Included in the data submission; and

    b. Clearly indicated by a claim status code = '04' (Field MC038, PC025, DC031).

8. Provider ID. The Provider ID (MP003) is the unique identifier for a single provider and is derived from the service and billing provider data appearing in the claims files. 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, the provider data file shall contain two or more separate records for that same provider reflecting each of those physical locations. One record should be provided for each unique physical location.

9. 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. The minimum value is defined as the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage. Minimum Value measure is outlined in Section 1302 (d)(2)(C) of the Affordable Care Act. Plans may use the HHS MV calculator available at http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html; may apply a safe harbor developed by HHS and the IRS; or may, for nonstandard plans, provide an actuarial certification from a member of the American Academy of Actuaries.

10. Co-payment or co-insurance amounts. Co-payment or co-insurance amounts are to be reported in 2 separate fields in the medical, pharmacy, and dental claims file submissions.

11. Carriers and third-party administrators shall include records for services provided by out of network providers and services provided after member exceeds benefits with complete patient liability paid.

Subscriber and Member Identification Data Elements

Carriers and third-party administrators shall provide a unique identification number for each member and subscriber included in the submitted files, and shall maintain that unique identifier for each member and subscriber for the entire period of coverage for that individual.

Subscriber and member identifiers shall be:

1. Consistent across all files that contain information about the subscriber or member;

2. Matched across the member, medical claims, pharmacy and dental files, as applicable, even where the claims are processed by a subcontractor such as a pharmacy benefits manager; and

3. Consistent with the following table, which lists the Subscriber and Member identifiers that are must be identical across files.

Matching Requirements for Subscriber/Member Identifiers Across Files				
Data Element Name*	**Member**	**Medical Claims****	**Dental Claims**	**Pharmacy Claims**
Subscriber Social Security Number	ME008	MC007, MC208***	DC007, DC202***	PC007, PC204***
Plan Specific Contract Number	ME009	MC008, MC208***	DC008, DC202***	PC008, PC204***
Member Suffix or Sequence Number	ME010	MC009	DC009	PC009
Member Social Security Number	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.				
***MC208, PC202, DC204 may be filled with the Carrier Plan Specific Contract Number. If the Carrier Plan Specific Contract Number is not available, please use the Subscriber Social Security Number.				

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:

1. 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).

2. 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).

3. 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).

General File Specifications

General Requirements for File Specifications

All carriers and health care claims processors shall abide by the following file specifications:

Filled fields. All fields shall be filled where applicable. Non-applicable text and date fields shall be set to null. Non-applicable integer and decimal fields shall be filled with one zero and shall not include decimal points.

Position. All text fields shall be left justified. All numeric fields shall be right justified.

Decimal points. Unless specifically stipulated, decimal points are not to be utilized. The decimal places listed under the "Length" column of the Detailed File Requirements of this Manual are inferred. Decimal points may be utilized in fields: MC061 (Quantity), DC901 (Quantity) and PC033 (Quantity Dispensed).

Signs. Minus signs (-) shall appear in the left-most position of numeric fields.

Over-punched signed integers or decimals shall not be utilized.

Individual elements and mapping. Individual data elements, data types, field lengths, field description/code assignments, and mapping locators (UB04, HCFA 1500, ANSI X12N 270/271, 835, 837) for each file type shall conform to the file specifications detailed in this Manual.

File Formats

The member 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 asterisk 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, unless otherwise stipulated.

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:

    a. Should be CCYYMMDD, when a value is provided, unless otherwise indicated in this Manual.

    b. Must not be padded with leading or trialing spaces or tabs.

    c. Must be left blank when not applicable or if a value is not available.

Header and Trailer Records

Header and Trailer Records. Each member file, each medical, pharmacy, and dental claims file, and each provider 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.

The header and trailer record formats shall conform to the following specifications.

Member File

Member File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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	Number	6	Beginning of month covered for eligibility. CCYYMM
HD006	Period Ending Date	Number	6	End of month covered for eligibility. CCYYMM
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Member File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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.

Member File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
TR004	Type of File	Text	2	ME Member Eligibility.
TR005	Period Beginning Date	Number	6	Beginning of month covered for eligibility. CCYYMM
TR006	Period Ending Date	Number	6	End of month covered for eligibility. CCYYMM
TR007	Extraction Date	Date	8	Date file was created.
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file.

Medical Claims File

Medical Claims File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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	Number	6	Beginning of paid period for claims. CCYYMM
HD006	Period Ending Date	Number	6	End of paid period for claims. CCYYMM
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Medical Claims File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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	Number	6	Beginning of paid period for claims. CCYYMM
TR006	Period Ending Date	Number	6	End of paid period for claims. CCYYMM
TR007	Extraction Date	Date	8	Date file was created.
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file.

Pharmacy Claims File

Pharmacy Claims File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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	Number	6	Beginning of paid period for claims. CCYYMM
HD006	Period Ending Date	Number	6	End of paid period for claims. CCYYMM
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Pharmacy Claims File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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	Number	6	Beginning of paid period for claims. CCYYMM
TR006	Period Ending Date	Number	6	End of paid period for claims. CCYYMM
TR007	Extraction Date	Date	8	Date file was created.
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file.

Dental Claims File

Dental Claims Header File Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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	Number	6	Beginning of paid period for claims. CCYYMM
HD006	Period Ending Date	Number	6	End of paid period for claims. CCYYMM
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Dental Claims Trailer File Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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	Number	6	Beginning of paid period for claims. CCYYMM
TR006	Period Ending Date	Number	6	End of paid period for claims. CCYYMM
TR007	Extraction Date	Date	8	Date file was created.
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file.

Provider File

Provider File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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	Number	6	Beginning of paid period for claims. CCYYMM
HD006	Period Ending Date	Number	6	End of paid period for claims. CCYYMM
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Provider File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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	Number	6	Beginning of span of coverage period.
TR006	Period Ending Date	Number	6	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.

Detailed File Requirements

Detailed Member File Specifications – File Layout

The member file shall be submitted using the following specifications:

Member File Detailed Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
ME001	Payer	Text	8	Payer submitting payments NHID Submitter Code.
ME002	National Plan ID	Text	30	CMS National Plan ID.
ME003	Insurance Type Code/Product	Text	2	See Appendix I/Table 1 – Insurance Type/Product Code-Eligibility File.
ME004	Start Year	Number	4 (0)	Year for which eligibility is reported in this submission. CCYY format.
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.
ME006	Insured Group or Policy Number	Text	50	Group or policy number (not the number that uniquely identifies the subscriber).
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

Member File Detailed Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
ME008	Subscriber Social Security Number	Text	9	Subscriber's social security number. Do not include dashes. Leave blank if not available.
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.
ME010	Member Suffix or Sequence Number	Text	20	Uniquely identifies the member within the contract.
ME011	Member Social Security Number	Text	9	Member's social security number. Do not include dashes. Leave blank if not available.
ME012	Individual Relationship Code	Text	2	See Appendix I/Table 2 – Relationship Codes.
ME013	Member Gender	Text	1	M…Male F…Female U…Unknown O…Other
ME014	Member Date of Birth	Date	8	Date of birth of member.
ME015	Member City Name	Text	30	City name of member.
ME016	Member State or Province	Text	2	As defined by the US Postal Service.
ME017	Member ZIP Code	Text	9	ZIP code of member – may include non-US codes. Do not include dash.
ME018	Medical Coverage	Text	1	Y…Yes N…No
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

Member File Detailed Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
ME020	Dental Coverage	Text	1	Y…Yes, member has dental coverage in the period defined with this payer N…No, member does not have dental coverage in the period defined with this payer
ME021	Race 1	Text	6	See Appendix I/Table 3 – Race 1/Race 2.
ME022	Race 2	Text	6	See Appendix I/Table 3 – Race 1/Race 2.
ME023	Placeholder			
ME024	Hispanic Indicator	Text	1	Y…Yes, member is Hispanic/Latino/Spanish N…No, member is not Hispanic/Latino/Spanish U…Unknown
ME025	Ethnicity 1	Text	6	See Appendix I/Table 4 – Ethnicity 1/ Ethnicity 2.
ME026	Ethnicity 2	Text	6	See Appendix I/Table 4 – Ethnicity 1/ Ethnicity 2.
ME027	Placeholder			
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
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…Medicaid MCR…Medicare

Member File Detailed Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				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
ME030	Market Category	Text	4	Three or four digit character code for identifying market category. Employer size is based on the number of eligible employees in the group as define in INS 4100, (INS 4103.03 (g) for the Small Group market, INS 4104.03 (i) for the Large Group market). 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 through a qualified association trust

Member File Detailed Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				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 medical health insurance SIN…Policies sold and issued as student individual health insurance that is not major medical coverage

Member File Detailed Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
ME031	NH Health Protection Program	Text	4	For enrollees in the New Hampshire Health Protection Program (NHHPP), indicate if enrollee is part of the Premium Assistance Program (PAP) or Health Insurance Premium Payment (HIPP). Leave blank if enrollee is not a member of the NHHPP. PAP…Premium Assistance Program HIPP…Health Insurance Premium Payment
ME032	Group Name	Text	90	Name of the group which the member is covered by. If the member is part of a group of one or non-group, indicate "I" for individual.
ME101	Subscriber Last Name	Text	60	
ME102	Subscriber First Name	Text	35	
ME103	Subscriber Middle Initial	Text	1	
ME104	Member Last Name	Text	60	
ME105	Member First Name	Text	35	
ME106	Member Middle Initial	Text	1	
ME201	Placeholder			
ME203	Member's Assigned PCP	Text	10	National Provider ID of the member's Primary Care Physician as designated by healthcare claims processor.
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. This field may not be available for all market segments.
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.

Member File Detailed Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
ME206	Minimum Value	Number	3 (0)	For the plan reported in ME204, report the Minimum Value as described in Part Ins4009.03 (i). This is reported as a percentage. This field may be left blank.
ME207	Exchange Indicator	Text	1	The plan reported in ME204 was available on the Exchange Marketplace in the month and year reflected in ME004 and ME005. Y…Yes N…No
ME208	High Deductible Health Plan	Text	1	The plan reported in ME204 meets the IRS definition of a HDHP. Y…Yes N…No U…Unknown
ME209	Active Enrollment	Text	1	The plan reported in ME204 was open for enrollment in the year and month reflected in ME004 and ME005. Y…Yes N…No
ME210	New Coverage	Text	1	The plan reported in ME204 was being offered for the first time in the reporting year reflected in ME004. Y…Yes N…No
ME211	Placeholder			
ME899	Record Type	Text	2	ME
ME900	Plan State	Text	2	State in which the plan is sold or used. State codes are maintained by the US Postal Service.
ME901	Advanced Premium Tax Credit	Number	5(2)	Dollar value of Advanced Premium Tax Credit (APTC) subsidy. This would be populated if ME204 is populated. May be submitted at the subscriber level

Member File Detailed Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
ME902	NAIC Number	Text	5	Number that the National Association of Insurance Commissioners (NAIC) assigns to each company.
ME903	Grandfather Plan Indicator	Text	1	Indicates if a plan qualifies as a “Grandfathered” or “Transitional Plan” under the Affordable Care Act (ACA). Please see definition for “grandfathered” and “transitional” in HHS rules 45-CFR-147.140: https://www.federalregister.gov/select- citation/2013/06/03/45-CFR-147. The values of the indicator are as follows: 1= Grandfathered; 2 = Non-Grandfathered; 3 =Transitional; 4 = Not Applicable.
ME904	Metal Value	Text	10	The metal representation of the plan reported in ME204 on the Exchange Marketplace.

Detailed Member File Specifications – Mapping Standards

The mapping for the member file shall conform to the following national standards:

Member 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	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 Social Security Number	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
ME017	Member ZIP Code	271/2100C/N4/ /03, 271/2100D/N4/ /03
ME018	Medical Coverage	N/A

Member File Mapping and Format Information		
Data Element #	**Element**	**HIPAA Reference Transaction Set/Loop/Segment/Qualifier/Data Element**
ME019	Prescription Drug Coverage	N/A
ME020	Dental Coverage	N/A
ME021	Race 1	N/A
ME022	Race 2	N/A
ME023	Placeholder	N/A
ME024	Hispanic Indicator	N/A
ME025	Ethnicity 1	N/A
ME026	Ethnicity 2	N/A
ME027	Placeholder	N/A
ME028	Primary Insurance Indicator	N/A
ME029	Coverage Type	N/A
ME030	Market Category	N/A
ME031	Group Name	N/A
ME032	NH Health Protection Program	N/A
ME101	Subscriber Last Name	270/2100C/NM1/IL/1/3
ME102	Subscriber First Name	270/2100C/NM1/IL/1/4
ME103	Subscriber Middle Initial	270/2100C/NM1/IL/1/5
ME104	Member Last Name	270/2100D/NM1/QC/1/3
ME105	Member First Name	270/2100D/NM1/QC/1/4
ME106	Member Middle Initial	270/2100D/NM1/QC/1/5
ME201	Placeholder	N/A

Member File Mapping and Format Information		
Data Element #	**Element**	**HIPAA Reference Transaction Set/Loop/Segment/Qualifier/Data Element**
ME203	Member's Assigned PCP	Loop 2000B SBR02 = 18 – ELSE – Loop
ME204	HIOS Plan ID	N/A
ME205	Plan Effective Date	N/A
ME206	Minimum Value	2010CA Segment N301
ME207	Exchange Indicator	N/A
ME208	High Deductible Health Plan	N/A
ME209	Active Enrollment	N/A
ME210	New Coverage	N/A
ME211	Placeholder	
ME899	Record Type	N/A
ME900	Plan State	N/A
ME901	Advanced Premium Tax Credit	N/A
ME902	NAIC Number	N/A
ME903	Grandfather Plan Indicator	N/A
ME904	Metal Value	N/A

Detailed Medical Claims File Specifications – File Layout

The medical claims file shall be submitted using the following specifications:

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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 I/Table 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 I/Table 2 – Relationship Codes.

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
MC012	Member Gender	Text	1	M…Male F…Female U…Unknown O…Other
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 I/Table 6 – Point of Origin Codes.
MC022	Discharge Hour	Text	2 (0)	Required for all inpatient claims. Time is expressed in military time – HH.

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
MC023	Discharge Status	Text	2	See Appendix I/Table 7 – Discharge Status.
MC024	Service Provider Number	Text	30	Payer assigned servicing provider number by the payer for internal identification purposes.
MC025	Service Provider Tax ID Number	Text	10	Federal taxpayer's identification number. *If the tax id is a provider's social security number, use 'SSN' and 'NA' if unavailable.*
MC026	National Service Provider ID	Text	10	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 taxonomy code that is assigned to 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.

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
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.
MC036	Type of Bill – Institutional	Text	3	For facility claims only 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

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				2…Hospital Based or Independent Renal Dialysis Center 3…Free Standing Outpatient Rehabilitation Facility (ORF) 5…Comprehensive Outpatient Rehabilitation Facility (ORF) 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 I/Table 8 – Place of Service – Professional.
MC038	Service Line Status	Text	2	Describes the payment status of the specific service line record. See Appendix I/Table 9 – Claim Status.

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
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 -11	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
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.

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
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-9/10-CM Procedure Code	Text	7	Primary ICD-9/10-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	12 (0)	Count of services performed. Decimal point allowed in this field.
MC062	Charge Amount	Number	10 (2)	The full, undiscounted total and service-specific charges billed by the provider.
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)	Amount in dollars met by the patient/family in a deductible plan
MC068	Patient Account/Control Number	Text	20	
MC069	Discharge Date	Date	8	Required for all inpatient(s).
MC070	Service Provider Country Name	Text	30	

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
MC071	DRG	Text	7	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	10	This is the NPI for the billing provider.
MC078	Billing Provider Organization or Last Name	Text	60	
MC101	Subscriber Last Name	Text	60	
MC102	Subscriber First Name	Text	35	
MC103	Subscriber Middle Initial	Text	1	
MC104	Member Last Name	Text	60	

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
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 ICD-9 or ICD-10. 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 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	When a TPA processes claims on behalf of the carrier, for each claim, report the carrier specific contract number or subscriber/member social security number. 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.

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
MC209	Practitioner Group Practice	Text	60	Name of group practice to which a practitioner is affiliated if different from MC078.
MC210	Coordination of Benefits/Third Party Liability Amount	Number	10 (2)	Coordination of Benefits (COB)/Third Party Liability (TPL) is the 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 4…DRG 5…Pay for Performance 6…Global Payment 7…Other

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				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 MP005 = 1, 2, or 3. Y…Yes N…No
MC218	Claim Processing Level Indicator	Text	1	1…Claim Level 2…Service Line level
MC219	Denied Claim Indicator	Text	1	1…Fully Paid – the entire claim (all claim lines) 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-Fee For Service (FFS) payment arrangement such as capitation or a fully reimbursed COB claim 4…No Payment – no payment made for any of the claim lines, for reasons other than non FFS payment arrangement or application to deductible/co-pay.
MC220	Denial Reason	Text	4	Required when Service Line Status (MC038) = 4 or 22 Use the most appropriate code from either the Claim Adjustment Reason Codes (CARC) set or the Remittance Advice Remark Codes (RARC) set.
MC221	Procedure Modifier – 3	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.
MC222	Procedure Modifier – 4	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
MC223	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.
MC899	Record Type	Text	2	MC
MC900	In Network Indicator	Text	1	A Yes/No indicator that specifies that the provider (not the benefit) is within the health plan network. Valid codes: Y=Yes, N=No
MC901	Unit of Measure	Text	2	Type of units reported in MC061. Codes accepted DA=days, MN=minutes, UN=units. If MC061 is not reported, MC901=NA

Detailed Medical Claim File Specifications – Mapping Standards

The mapping for the medical claims file shall conform to the following national standards:

Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-04 Form Locator**	**UB-04 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
MC005A	Version Number	N/A	N/A	N/A	N/A	N/A
MC006	Insured Group or Policy Number	62 (A-C)	30/10	11C	DA0-10.0	837/2000B/SBR/ /03
MC007	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
MC009	Member Suffix or Sequence Number	N/A	N/A	N/A	N/A	N/A
MC010	Member Social Security Number	N/A	N/A	N/A	N/A	835/2100/NM1/34/08

Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-04 Form Locator**	**UB-04 Record Type/Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/Data Element**
MC011	Individual Relationship Code	59 (A-C)	30/18	6	DA0-17.0	837/2000B/SBR/ /02, 837/2000C/PAT/ /01
MC012	Member Gender	11	20/7	3	CA0-09.0	837/2010CA/DMG/03
MC013	Member Date of Birth	10	20/8	3	CA0-08.0	837/2010CA/DMG/D8/02
MC014	Member City Name	9	20/14	5	CA0-13.0	837/2010CA/N4/ /01
MC015	Member State or Province	9	20/15	5	CA0-14.0	837/2010CA/N4/ /02
MC016	Member ZIP Code	9	20/16	5	CA0-15.0	837/2010CA/N4/ /03
MC017	Paid Date (AP Date)	N/A	N/A	N/A	N/A	N/A
MC018	Admission Date	12	20/17	N/A	N/A	837/2300/DTP/435/03
MC019	Admission Hour	13	20/18	N/A	N/A	837/2300/DTP/435/03
MC020	Admission Type	14	20/10	N/A	N/A	837/2300/CL1/ /01
MC021	Admission Source	15	20/11		N/A	837/2300/CL1/ /02
MC022	Discharge Hour	16	20/22		N/A	837/2300/DTP/096/03
MC023	Discharge Status	**17**	20/21	N/A	N/A	837/2300/CL1/ /03
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

Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-04 Form Locator**	**UB-04 Record Type/Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/Data Element**
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 Last Name or Organization Name	1	10/12	33	BA0-18.0, BA0-19.0	835/2100/NM1/82/03
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	Service Line Status	N/A	N/A	N/A	N/A	835/2100/CLP/ /02
MC039	Admitting Diagnosis	69	70/25	N/A	N/A	837/2300/HI/BJ/02-2

Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-04 Form Locator**	**UB-04 Record Type/Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/Data Element**
MC040	E-Code	72	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	67A	70/5	21.2	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-1
MC043	Other Diagnosis – 2	67B	70/6	21.3	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-2
MC044	Other Diagnosis – 3	67C	70/7	21.4	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-3
MC045	Other Diagnosis – 4	67D	70/8	N/A	EA0-35.0, GX0-34.0, GU0-15.0	837/2300/HI/BF/02-4
MC046	Other Diagnosis – 5	67E	70/9	N/A	N/A	837/2300/HI/BF/02-5
MC047	Other Diagnosis – 6	67F3	70/10	N/A	N/A	837/2300/HI/BF/02-6
MC048	Other Diagnosis – 7	67G	70/11	N/A	N/A	837/2300/HI/BF/02-7
MC049	Other Diagnosis – 8	67H	70/12	N/A	N/A	837/2300/HI/BF/02-8
MC050	Other Diagnosis – 9	67I	N/A	N/A	N/A	837/2300/HI/BF/02-9
MC051	Other Diagnosis –10	67J	N/A	N/A	N/A	837/2300/HI/BF/02-10
MC052	Other Diagnosis –11	67K	N/A	N/A	N/A	837/2300/HI/BF/02-11
MC053	Other Diagnosis –12	67L	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

Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-04 Form Locator**	**UB-04 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	74, 74 (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	Fee for Service Equivalent	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

Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-04 Form Locator**	**UB-04 Record Type/Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/Data Element**
MC068	Patient Account/Control Number	3	N/A	N/A		837/2300/CLM/1
MC069	Discharge Date					
MC070	Service Provider Country Name	N/A	N/A	N/A	N/A	N/A
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
MC076	Billing Provider Number	N/A	N/A	N/A	N/A	N/A
MC077	National Billing Provider Number ID	N/A	N/A	N/A	N/A	N/A
MC078	Billing Provider Organization or Last Name	N/A	N/A	N/A	N/A	N/A
MC101	Encrypted Subscriber Last Name	N/A	N/A	N/A	N/A	837/2110BA/NM1/IL/1/3
MC102	Encrypted Subscriber First Name	N/A	N/A	N/A	N/A	837/2110BA/NM1/IL/1/4

Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-04 Form Locator**	**UB-04 Record Type/Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/Data Element**
MC103	Encrypted Subscriber Middle Initial	N/A	N/A	N/A	N/A	837/2110BA/NM1/IL/1/5
MC104	Encrypted Member Last Name	N/A	N/A	N/A	N/A	837/2110CA/NM1/QC/1/3
MC105	Encrypted Member First Name	N/A	N/A	N/A	N/A	837/2110CA/NM1/QC/1/4
MC106	Encrypted Member Middle Initial	N/A	N/A	N/A	N/A	837/2110CA/NM1/QC/1/5
MC200	ICD Indicator	N/A	N/A	N/A	N/A	Set value here based upon Loop 2300 Segment H101-01 starting with the letter A
MC202	Other ICD-CM Procedure Code – 2	N/A	N/A	N/A	N/A	837/2300 H102-1=BQ (ICD-9) or = BBQ (ICD-10)
MC203	Other ICD-CM Procedure Code – 3	N/A	N/A	N/A	N/A	837/2300 H102-1=BQ (ICD-9) or = BBQ (ICD-10)
MC204	Other ICD-CM Procedure Code – 4	N/A	N/A	N/A	N/A	837/2300 H102-1=BQ (ICD-9) or = BBQ (ICD-10)
MC205	Other ICD-CM Procedure Code – 5	N/A	N/A	N/A	N/A	837/2300 H102-1=BQ (ICD-9) or = BBQ (ICD-10)

Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-04 Form Locator**	**UB-04 Record Type/Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/Data Element**
MC206	Other ICD-CM Procedure Code – 6	N/A	N/A	N/A	N/A	837/2300 H102-1=BQ (ICD-9) or = BBQ (ICD-10)
MC207	Carrier Associated with Claim	N/A	N/A	N/A	N/A	N/A
MC208	Carrier Plan Specific contract Number or Subscriber/Member Social Security Number	N/A	N/A	N/A	N/A	N/A
MC209	Practitioner Group Practice	N/A	N/A	N/A	N/A	N/A
MC210	Coordination of Benefits/Third Party Liability Amount	N/A	N/A	N/A	N/A	835/2320 AMT02
MC211	Cross Reference Claims ID	N/A	N/A	N/A	N/A	N/A
MC212	Allowed Amount	N/A	N/A	N/A	N/A	837/2300 HCP02
MC215	Service Line Type	N/A	N/A	N/A	N/A	N/A
MC216	Payment Arrangement Type	N/A	N/A	N/A	N/A	Loop 2400 Segment HCP01
MC217	Pay for Performance Flag	N/A	N/A	N/A	N/A	N/A
MC218	Claim Processing Level Indicator	N/A	N/A	N/A	N/A	N/A
MC219	Denied Claim Indicator	N/A	N/A	N/A	N/A	Loop 2430 CAS identification

Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-04 Form Locator**	**UB-04 Record Type/Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/Data Element**
MC220	Denial Reason	N/A	N/A	N/A	N/A	Loop 2430 CAS identification
MC221	Procedure Modifier – 3	N/A	N/A	N/A	N/A	837/2430 SVD03-05
MC222	Procedure Modifier – 4	N/A	N/A	N/A	N/A	837/2430 SVD03-06
MC899	Record Type	N/A	N/A	N/A	N/A	N/A
MC900	In Network Indicator	N/A	N/A	N/A	N/A	N/A
MC901	Unit of Measure	N/A	N/A	N/A	N/A	N/A

Detailed Pharmacy Claim File Specifications – File Layout

The pharmacy claims file shall be submitted using the following specifications:

Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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 I/Table 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 I/Table 2 – Relationship Codes.

Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
PC012	Member Gender	Text	1	M…Male F…Female U…Unknown O…Other
PC013	Member Date of Birth	Date	8	
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	10	Required if National Provider ID is mandated for use under HIPAA.
PC022	Pharmacy Location City	Text	30	City name of pharmacy.
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 I/Table 9 – Claim Status.

Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
PC026	Drug Code	Text	11	NDC Code in CMS configuration 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). Examples: 0, 1, 2, 00, 01 - XX
PC029	Generic Drug Indicator	Text	2	01…No, branded drug 02…Yes, generic drug
PC030	Dispense as Written Code	Text	1	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	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. Decimal point allowed in this field.
PC034	Days' Supply	Number	4	Estimated number of days the prescription will last.

Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
PC035	Charge Amount	Number	10 (2)	The full, undiscounted total and service-specific charges billed by the provider.
PC036	Paid Amount	Number	10 (2)	Includes any withhold amounts.
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 Amount	Number	10 (2)	Coinsurance amount in dollars.
PC042	Deductible Amount	Number	10 (2)	Deductible amount in dollars.
PC043	Prescription Number	Text	20	The number generated by the pharmacy when a new prescription is ordered for a person - a unique code assigned to a person's prescribed medicine
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	10	Provider NPI.
PC101	Subscriber Last Name	Text	60	
PC102	Subscriber First Name	Text	35	
PC103	Subscriber Middle Initial	Text	1	
PC104	Member Last Name	Text	60	

Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
PC105	Member First Name	Text	35	
PC106	Member Middle Initial	Text	1	
PC203	Carrier Associated with Claim	Text	8	For each claim, the NAIC code of the carrier 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.
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 Processing Level Indicator	Text	1	1…Claim Level 2…Service Line level
PC215	Service Line Type	Text	1	Report the code that defines the claim line status in terms of adjudication: O…Original V…Void R…Replacement

Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				B…Back Out A…Amendment
PC216	Denied Claim Indicator	Text	1	1…Fully Paid – The entire claim (all claim lines) 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 or a fully reimbursed COB claim 4…No Payment – No payment made for any of the claim lines, for reasons other than non FFS payment arrangement or application to deductible/co-pay.
PC217	Denial Reason	Text	4	Required when Service Line Status (PC025) = 4 or 22. Use the most appropriate code from either the Claim Adjustment Reason Codes (CARC) set or the Remittance Advice Remark Codes (RARC) set. NCPDP codes are also acceptable.
PC899	Record Type	Text	2	PC
PC900	Mail Order Pharmacy Indicator	Text	1	A yes/no indicator that specifies that the pharmacy is a mail order pharmacy. Valid codes: Y=Yes, N=No
PC901	In Network Indicator	Text	1	A yes/no indicator that specifies that the provider (not the benefit) is within the health plan network. Valid codes: Y=Yes, N=No
PC902	Version Number	Number	4(0)	Version number of this claim. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line

Detailed Pharmacy Claim File Specifications – Mapping Standards

The pharmacy claims file shall conform to the following national standards:

Pharmacy Claims File Mapping and Format Information		
Data Element	**Element**	**National Council for Prescription Drug Programs Field #**
PC001	Payer	879
PC002	Plan ID	879
PC003	Insurance Type/Product Code	N/A
PC004	Payer Claim Control Number	993-A7
PC005	Line Counter	N/A
PC006	Insured Group Number	301-C1
PC007	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	Paid Date (AP Date)	N/A
PC018	Pharmacy Number	202-B2

Pharmacy Claims File Mapping and Format Information		
Data Element	**Element**	**National Council for Prescription Drug Programs Field #**
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
PC024	Pharmacy ZIP Code	835-5R
PC024A	Pharmacy Country Name	N/A
PC025	Service Line 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

Pharmacy Claims File Mapping and Format Information		
Data Element	**Element**	**National Council for Prescription Drug Programs Field #**
PC039	Dispensing Fee	507-F7
PC040	Copay Amount	518-FI
PC041	Coinsurance Amount	518-FI
PC042	Deductible Amount	505-F5
PC043	Prescription Number	402-D2
PC044	Prescribing Physician First Name	717
PC045	Prescribing Physician Middle Name	N/A
PC046	Prescribing Physician Last Name	716
PC047	Prescribing Physician Number	411-DB
PC101	Subscriber Last Name	716
PC102	Subscriber First Name	717
PC103	Subscriber Middle Initial	718
PC104	Member Last Name	716
PC105	Member First Name	717
PC106	Member Middle Initial	718
PC203	Carrier Associated with Claim	N/A
PC204	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	N/A
PC211	Cross Reference Claims ID	N/A
PC212	Allowed Amount	N/A

Pharmacy Claims File Mapping and Format Information		
Data Element	**Element**	**National Council for Prescription Drug Programs Field #**
PC213	HIOS Plan ID	N/A
PC214	Claim Processing Level Indicator	N/A
PC215	Service Line Type	N/A
PC216	Denied Claim Indicator	N/A
PC217	Denial Reason	N/A
PC899	Record Type	N/A
PC900	Mail Order Pharmacy Indicator	N/A
PC901	In Network Indicator	N/A
PC902	Version Number	N/A

Detailed Dental Claims File Specifications – File Layout

The dental claims file shall be submitted using the following specifications:

Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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 I/Table 5 – Insurance Type/Product Code – Claims Files.
DC004	Payer Claim Control Number	Text	35	Must apply to entire claim and be unique within payer's system.
DC005	Line Counter	Number	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 I/Table 2 – Relationship Codes.
DC012	Member Gender	Text	1	M…Male F…Female U…Unknown

Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				O…Other
DC013	Member Date of Birth	Date	8	
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. *If the tax id is a provider's social security number use 'SSN' and 'NA' if unavailable.*
DC020	National Service Provider ID	Text	10	Required if National Provider ID is mandated for use under HIPAA.
DC021	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
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.

Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
DC026	Service Provider Specialty	Text	10	National Uniform Claims Committee (NUCC) standard taxonomy code that is assigned to this provider for this line of service.
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 I/Table 8 – Place of Service – Professional.
DC031	Claim Status	Text	2	See Appendix I/Table 9 – 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)	The full, undiscounted total and service-specific charges billed by the provider.
DC038	Paid Amount	Number	10 (2)	Includes any withhold amounts.
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)	Deductible amount in dollars.
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

Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				should be the identifier used by the payer for internal identification purposes, and does not routinely change.
DC043	National Billing Provider Number ID	Text	10	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.
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	2	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:

Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				00 - Entire Oral Cavity 01 - Maxillary arch 02 - Mandibular arch 10 – maxillary (upper) right 20 – maxillary (upper) left 30 – mandibular (lower) left 40 – mandibular (lower) right UL – Upper Left UR – Upper Right LL – Lower Left LR – Lower Right
DC206	Tooth Surface	Text	5	Tooth surface(s) that the service relates to. See Appendix I/Table 10 – Tooth Surface(s)
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 ICD-9 or ICD-10. 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

Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				by the provider.. 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. Shall be reported even when paid amount = 0 but member receives care.
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	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
DC218	Claim Processing Level Indicator	Text	1	1…Claim Level 2…Service Line Level
DC219	Denied Claim Indicator	Text	1	1…Fully Paid – The entire claim (all claim lines) 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 or a fully reimbursed COB claim 4…No Payment – No payment made for any of the claim lines, for reasons other than non FFS payment arrangement or application to deductible/co-pay.
DC220	Denial Reason	Text	4	Required when Service Line Status (DC031) = 4 or 22.

Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				Use the most appropriate code from either the Claim Adjustment Reason Codes (CARC) set or the Remittance Advice Remark Codes (RARC) set.
DC899	Record Type	Text	2	DC
DC900	In Network Indicator	Text	1	A Yes/No indicator that specifies that the provider (not the benefit) is within the health plan network. Valid codes: Y=Yes, N=No
DC901	Quantity	Number	12 (0)	Count of services performed.

Detailed Dental Claim File Specifications – Mapping Standards

The dental claims file shall conform to the following national standards:

Dental Claims File Mapping and Format Information			
Data Element #	**Data Element Name**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/Segment/Qualifier/Data Element**
DC001	Payer	N/A	N/A
DC002	National Plan Id	N/A	N/A
DC003	Insurance Type/Product Code	N/A	835/2100/CLP/ /06
DC004	Payer Claim Control Number	N/A	835/2100/CLP/ /07
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	837/2400/LX/ /01
DC006	Insured Group or Policy Number	DA0-10.0	837/2000B/SBR/ /03
DC007	Subscriber Social Security Number	N/A	837/2010BA/REF/SY/02
DC008	Plan Specific Contract Number	N/A	835/2100/NM1/MI/08
DC009	Member Suffix or Sequence Number	N/A	N/A
DC010	Member Social Security Number	N/A	835/2100/NM1/34/09
DC011	Individual Relationship Code	DA0-17.0	837/2000B/SBR/ /02, 837/20000C/PAT/ /01
DC012	Member Gender	CA0-09.0	837/2010BA/DMB/ /03, 837/2010CA/DMB/ /03
DC013	Member Date of Birth	CA0-08.0	837/2010BA/DMB/D8/02, 837/2010CA/DMB/D8/02
DC014	Member City Name of Residence	CA0-13.0	837/2010BA/N4/ /01, 837/2010CA/N4/ /01
DC015	Member State or Province	CA0-14.0	837/2010BA/N4/ /02, 837/2010CA/N4/ /02

Dental Claims File Mapping and Format Information			
Data Element #	**Data Element Name**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/Segment/Qualifier/Data Element**
DC016	Member ZIP Code of Residence	CA0-15.0	837/2010BA/N4/ /03, 837/2010CA/N4/ /03
DC017	Date Service Approved	N/A	835/Header Financial Information/BPR/ /16
DC018	Service Provider Number	N/A	835/21000/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09
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	835/2100/NM1/FI/09
DC020	National Service Provider ID	N/A	837/2310B/NM1/XX/09
DC021	Service Provider Entity Type Qualifier	N/A	837/2310B/NM1/82/02
DC022	Service Provider First Name	BA0-20.0	837/2310B/NM1/82/04
DC023	Service Provider Middle Name	BA0-21.0	837/2310B/NM1/82/05
DC024	Service Provider Last Name or Organization Name	BA0-18.0, BA0-19.0	837/2310B/NM1/82/03
DC025	Service Provider Suffix	BA0-22.0	837/2310B/NM1/82/07
DC026	Service Provider Specialty	N/A	837/2310B/PRV/PXC/03
DC027	Service Provider City name	BA1-09.0, 15.0	837/2310C/N4/ /01
DC028	Service Provider State or Province	BA1-10.0, 16.0	837/2310C /N4/ /02
DC029	Service Provider ZIP Code	BA1-11.0, 17.0	837/2310C /N4/ /03

Dental Claims File Mapping and Format Information			
Data Element #	**Data Element Name**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/Segment/Qualifier/Data Element**
DC030	Facility Type – Professional	FA0-07.0, GU0-0.50	837/2300/CLM/05-1
DC031	Claim Status		835/2100/CLP/ /02
DC032	CDT Code	FA0-09.0, FB0-15.0, GU0-07.0	837/2400/SV3/AD/01-2
DC033	Procedure Modifier – 1	FA0-10.0, GU0-08.0	837/2400/SV3/AD/01-3
DC034	Procedure Modifier – 2	FA0-11.0	837/2400/SV3/AD/01-4
DC035	Date of Service – From	N/A	837/2400/DTP/472/D8/03, 837/2300/DTP/472/D8/03
DC036	Date of Service – Thru	FA0-05.0, FA0-06.0	837/2400/DTP/472/D8/03, 837/2300/DTP/472/D8/03
DC037	Charge Amount	FA0-13.0	837/2400/SV3/ /02
DC038	Paid Amount	N/A	835/2110/SVC/ /03
DC039	Copay Amount	N/A	835/2110/CAS/PR/3-03
DC040	Coinsurance Amount	N/A	835/2110/CAS/PR/2-03
DC041	Deductible Amount	N/A	835/2110/CAS/PR/1-03
DC042	Billing Provider Number	N/A	837/2010BB/REF/G2/02
DC044	National Billing Provider ID	N/A	837/2010AA/NM1/XX/09
DC044	Billing Provider Last Name	N/A	837/2010AA/NM1/ /03
DC101	Subscriber Last Name	N/A	837/2010BA/NM1/ /03
DC102	Subscriber First Name	N/A	837/2010BA/NM1/ /04
DC103	Subscriber Middle Initial	N/A	837/2010BA/NM1/ /05

Dental Claims File Mapping and Format Information			
Data Element #	**Data Element Name**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/Segment/Qualifier/Data Element**
DC104	Member Last Name	N/A	837/2010BA/NM1/ /03, 837/2010CA/NM1/ /03
DC105	Member First Name	N/A	837/2010BA/NM1/ /04, 837/2010CA/NM1/ /04
DC106	Member Middle Initial	N/A	837/2010BA/NM1/ /05, 837/2010CA/NM1/ /05
DC201	Carrier Associated with Claim	N/A	N/A
DC202	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	N/A	N/A
DC203	Practitioner Group Practice	N/A	N/A
DC204	Tooth Number/Letter	N/A	837/2400 TOO02
DC205	Dental Quadrant	N/A	837/2400 SV304
DC206	Tooth Surface		837/2400 TOO03
DC207	Claim Version	N/A	N/A
DC208	Diagnosis Code	N/A	837/2300 H101-2
DC209	ICD Indicator	N/A	N/A
DC211	Cross Reference Claims ID	N/A	N/A
DC212	Allowed Amount	N/A	837/2300 HCP02
DC213	HIOS Plan ID	N/A	N/A
DC215	Service Line Type	N/A	N/A
DC218	Claim Processing Level Indicator	N/A	N/A
DC219	Denied Claim Indicator	N/A	N/A
DC220	Denial Reason	N/A	N/A
DC899	Record Type	N/A	N/A

Dental Claims File Mapping and Format Information			
Data Element #	**Data Element Name**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/Segment/Qualifier/Data Element**
DC900	In Network Indicator	N/A	N/A
DC901	Quantity	N/A	N/A

Detailed Provider File Specifications – File Layout

The provider file shall be submitted using the following specifications:

Provider File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**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. *If the tax id is a provider's social security number use 'SSN' and 'NA' if unavailable*.
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

Provider File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				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
MP006	Provider First Name	Text	35	Individual first name. Leave blank if provider is a facility or organization.
MP007	Provider Middle Name or Initial	Text	25	
MP008	Provider Last Name or Organization Name	Text	60	Full name of provider organization or last name of individual provider.
MP009	Provider Suffix	Text	10	Example: Jr; Set as leave blank if provider is an organization. Do not use credentials such as MD or PhD.
MP010	Provider Specialty	Text	10	National Uniform Claims Committee (NUCC) health care provider taxonomy code assigned to this provider.
MP011	Provider Office Street Address	Text	50	Physical address – address where provider delivers health care services.
MP012	Provider Office City	Text	30	Physical address – address where provider delivers health care services.
MP013	Provider Office State	Text	2	Physical address – address where provider delivers health care services. Use postal service standard 2 letter abbreviations.

Provider File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
MP014	Provider Office Zip	Text	9	Physical address – address where provider delivers health care services. Minimum 5 digit code. Do not include dashes.
MP015	Provider DEA Number	Text	12	
MP016	Provider NPI	Text	10	
MP017	Provider State License Number	Text	30	

MP018	Entity Code	Text	2	Enter the value that defines the entity provider type. Required when MP005 does not = 1. Values: 1 Academic Institution 2 Adult Foster Care 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 18 Non-Hospital Connected Lab 19 Non-Hospital Connected Radiology Facility 20 Substance Abuse Facility 21 Licensed Hospital Satellite Emergency Facility 22 Hospital Emergency Center 23 Nursing Home 24 Pharmacy 25 Freestanding Ambulatory Surgery 26 School Based Health Center 27 Physician Group

Provider File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (Decimal)**	**Description/Codes/Sources**
				28 Dental Group Practice 29 Mental Health Facility (Non-Hospital) 30 Professional Group
MP899	Record Type	Text	2	MP

Appendix I – Referenced Code Tables

Table 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
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

Table 1 – Insurance Type/Product Code-Eligibility File	
Code	**Description**
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
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

Table 2 – Relationship Codes	
Code	**Description**
01	Spouse
02	Son or daughter
03	Father or Mother
04	Grandfather or Grandmother
05	Grandson or Granddaughter
06	Uncle or Aunt
07	Nephew or Niece

Table 2 – Relationship Codes	
Code	**Description**
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
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

Table 2 – Relationship Codes	
Code	**Description**
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
76	Dependent

Table 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
UNKNOW	Unknown/Not Specified

Table 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

Table 4 – Ethnicity 1/Ethnicity 2	
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

Table 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

Table 5 – Insurance Type/Product Code – Claims Files	
Code	**Description**
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
MH	Medigap Part A
MI	Medigap Part B
MO	Medicare Advantage (PPO)
OF	Other Federal Program (e.g., Black Lung)
SP	Supplemental Policy
TR	Tricare
TV	Title V
VA	Veterans Administration Plan
WC	Workers' Comp
ZZ	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)

Table 6 – Point of Origin Codes	
If MC020 = 4 (Newborn), then use the following values for 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
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

Table 7 – 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
40	Expired at home
41	Expired in a medical facility
42	Expired, place unknown

Table 7 – Discharge Status	
Code	**Description**
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)
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)

Table 7 – Discharge Status	
Code	**Description**
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)
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)

Table 8 – 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
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Unassigned

Table 8 – Place of Service – Professional	
Code	**Description**
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
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

Table 8 – Place of Service – Professional	
Code	**Description**
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Unlisted Facility

Table 9 – Claim Status	
Code	**Description**
01	Processed as primary
02	Processed as secondary
03	Processed as tertiary
04	Denied
06	Approved as amended
19	Processed as primary, forwarded to additional payer(s)
21	Processed as tertiary, forwarded to additional payer(s)
22	Reversal of previous payment
26	Documentation Claim - No Payment Associated
28	Repriced

Table 10 – Tooth Surface(s)	
Code	**Description**
B	Buccal
D	Distal
F	Facial
I	Incisal
L	Lingual/Palatal
M	Mesial
O	Occlusal

Appendix II – External Code Sources

Countries

American National Standards Institute

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

States, Zip Codes, and Other Areas of the US

U.S. Postal Service

https://www.usps.com/

National Provider Identifiers

National Plan & Provider Enumeration System

Centers for Medicare and Medicaid Services

https://nppes.cms.hhs.gov/NPPES/

Health Care Provider Taxonomy

National Uniform Claim Committee (NUCC)

http://www.nucc.org

International Classification of Diseases 9 & 10

World Health Organization

http://www.who.int/classifications/icd/en/

HCPCS

Centers for Medicare and Medicaid Services

https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS-Items/2015-Alpha-Numeric-HCPCS-File-%C2%A0.html

CPTs and Modifiers

American Medical Association

http://www.ama-assn.org/

Dental Procedure Codes and Identifiers

American Dental Association

http://www.ada.org/

National Drug Codes and Names

U.S. Food and Drug Administration

http://www.fda.gov/drugs/informationondrugs/ucm142438.htm

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

Standard Facility Billing Elements

National Uniform Billing Committee (NUBC)

http://www.nubc.org/

DRGs, APCs, and POA Codes

Centers for Medicare and Medicaid Services

http://www.cms.gov/

Claim Adjustment Reason Codes

Washington Publishing Company

https://x12.org/reference