

PROFESSIONAL SERVICES DATA REPORT SUBMISSION

This report details all fee-for-service and capitated encounters provided by health care practitioners and office facilities for the quarterly reporting period designated – First Quarter: Claims paid from January 1, 2017 through March 31, 2017; Second Quarter: Claims paid from April 1, 2017 through June 30, 2017; Third Quarter: Claims paid from July 1, 2017 through September 30, 2017; and Fourth Quarter: Claims paid from October 1, 2017 through December 31, 2017. Please provide information on all health care services provided to applicable insureds whether those services were provided by a practitioner or office facility located in-State or out-of-State.

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
P001	Record Identifier	1	A	1	1	100%	The value is 1	1 Professional Services	In the Professional Services file, this field must be 1.	
P002	Encrypted Enrollee's Identifier P	12	A	2	13	100%	Enrollee's unique identification number assigned by payor and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Eligibility, Pharmacy Claims, Institutional Services, and Dental Services Files) If the encryption algorithm for Patient ID changes, please contact MHCC before submitting	Cannot be entirely unknown values (0s, 1s, and 9s). Must be at least 3 characters long. Must be consistent with previous quarter i.e. the same patient is identified by the same ID across payers. Must be unique for each beneficiary.	
P003	Encrypted Enrollee's Identifier U	12	A	14	25	100%	Enrollee's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual. Leave UUID blank if it is not generated by the UUID software	Cannot be entirely unknown values (0s, 1s, and 9s). Must be 12 characters long. Alphabetical characters must be lower-case as generated by the UUID application. Must be consistent with previous quarter i.e. the same patient is identified by the same ID across payers	
P004	Enrollee Year and Month of Birth	8	N	26	33	100%	Date of enrollee's birth using 00 instead of day.	CCYYMM00	Year and month of birth must be valid.	
P005	Enrollee Sex	1	A	34	34	99%	Sex of the enrollee.	1 Male 2 Female	Value must be valid (see list of valid values in the Field Contents column).	
P006	Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	1	A	35	35		Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) or Health Resources Account(HRA)	0 No 1 Yes	Value must be valid (see list of valid values in the Field Contents column).	
P007	Enrollee Zip Code of Residence +4 digit add-on code	10	A	36	45	99%	Zip code of enrollee's residence.	5-digit US Postal Service code plus 4-digit add-on code. If 4-digit add on code is available, please use the format "XXXX-XXXX". If 4-digit add-on code is missing, please use the format of either "XXXX-0000" or "XXXX"	Value must be a valid US postal code. If any of the 4-digit add-on values are populated, they must all be populated. If the 4-digit add-on values are populated, the 6th digit must be a hyphen	
P008	Patient Covered by Other Insurance Indicator	1	A	46	46	95%	Indicates whether patient has additional insurance coverage.	0 No 1 Yes, other cover is primary 2 Yes, other coverage is secondary 9 Unknown	Value must be valid (see list of valid values in the Field Contents column).	
P009	Coverage Type	1	A	47	47		Patient's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not sold on MHBE) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 8 Small Business Options Program (SHOP) not sold on MHBE (definition of SHOP must follow what the Maryland Insurance Administration is using. See attachment at http://www.mdinsurance.state.md.us/sa/docs/documents/insurer/bulletins/15-27-definition-of-small-employer.pdf) A Student Health Plan B Individual Market (sold on MHBE) C Small Business Options Program (SHOP) sold on MHBE (definition of SHOP must follow what the Maryland Insurance Administration is using. See attachment at http://www.mdinsurance.state.md.us/sa/docs/documents/insurer/bulletins/15-27-definition-of-small-employer.pdf) Z Unknown	Value must be valid (see list of valid values in the Field Contents column).	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
P010	Source Company	1	A	48	48		Defines the payor company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.	1 Health Maintenance Organization 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 3 Third-Party Administrator (TPA) Unit This field is optional, but must be populated in the Eligibility file.	Value must be valid (see list of valid values in the Field Contents column).	
P011	Claim Related Condition	1	A	49	49		Describes connection, if any, between patient's condition and employment, automobile accident, or other accident.	0 Non-accident (default) 1 Work 2 Auto Accident 3 Other Accident 9 Unknown	Value must be valid (see list of valid values in the Field Contents column).	
P012	Practitioner Federal Tax ID	9	A	50	58	100%	Employer Tax ID of the practitioner, practice or office facility receiving payment for services.		Must be 9 characters long. Value must be a valid federal tax ID.	
P013	Participating Provider Status	1	A	59	59	95%	Indicates if the service was provided by a provider that participates in the payor's network.	1 Participating 2 Non-Participating 3 Unknown/Not Coded 9 No Network for this Plan	Value must be valid (see list of valid values in the Field Contents column).	
P014	Record Status	1	A	60	60	95%	Describes payment and adjustment status of a claim. Adjustments include paying a claim more than once, paying additional services that may have been denied, or crediting a provider due to overpayment or paying the wrong provider.	1 Fee-for-service 8 Capitated or Global Contract Services	Value must be valid (see list of valid values in the Field Contents column).	
P015	Claim Control Number	23	A	61	83	100%	Internal payor claim number used for tracking.	Include on each record as this is the key to summarizing service detail to claim level.	Must be at least 2 characters long. Cannot be entirely unknown values (0s and 9s).	
P016	Claim Paid Date	8	N	84	91	100%	The date that the claim was paid. This date should agree with the paid date the Finance and Actuarial department is using in your organization. If there is a lag between the time a claim is authorized and paid, please contact MHCC for advice on which date field to use.	CCYYMMDD	Must be a valid date value.	
P017	Filler	2	N	92	93		Filler	Used to be Number of Diagnosis Codes		
P018	Filler	2	N	94	95		Filler	Used to be Number of Line Items		
P019	Diagnosis Code 1	7	A	96	102	99%	The primary ICD-9-CM or ICD-10-CM Diagnosis Code followed by a secondary diagnosis (up to 9 codes), if applicable at time of service.	Remove embedded decimal point.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
P020	Diagnosis Code 2	7	A	103	109		See comment under Diagnosis Code 1		Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
P021	Diagnosis Code 3	7	A	110	116		See comment under Diagnosis Code 1		Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
P022	Diagnosis Code 4	7	A	117	123		See comment under Diagnosis Code 1		Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
P023	Diagnosis Code 5	7	A	124	130		See comment under Diagnosis Code 1		Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
P024	Diagnosis Code 6	7	A	131	137		See comment under Diagnosis Code 1		Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
P025	Diagnosis Code 7	7	A	138	144		See comment under Diagnosis Code 1		Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
P026	Diagnosis Code 8	7	A	145	151		See comment under Diagnosis Code 1		Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
P027	Diagnosis Code 9	7	A	152	158		See comment under Diagnosis Code 1		Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
P028	Diagnosis Code 10	7	A	159	165		See comment under Diagnosis Code 1		Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
P029	Service From Date	8	N	166	173	100%	First date of service for a procedure in this line item.	CCYYMMDD	Must be a valid date value.	
P030	Service Thru Date	8	N	174	181	100%*	Last date of service for this line item.	CCYYMMDD If the Service Thru Date is not reported, then assume that the Service From Date (P029) and the Service Thru Date are the same.	Must be a valid date value.	
P031	Place of Service	2	A	182	183	99%	Two-digit numeric code that describes where a service was rendered.	See link for available codes: http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html	Value must be a valid place of service code(link of vaid codes provided in the Field Contents column).	
P032	Service Location Zip Code +4digit add-on code	10	A	184	193	95%	Zip code for location where service described was provided.	5-digit US Postal Service code plus 4-digit add-on code. If 4-digit add on code is available, please use the format "XXXX-XXXX". If 4-digit add-on code is missing, please use the format of either "XXXX-0000" or "XXXX".	Value must be a valid US postal code. If any of the 4-digit add-on values are populated, they must all be populated. If the 4-digit add-on values are populated, the 6th digit must be a hyphen.	
P033	Service Unit Indicator	1	A	194	194	95%	Category of service as it corresponds to Units data element.	0 values reported as zero (no allowed services) 1 Transportation (ambulance air or ground) Miles 2 Anesthesia Time Units 3 Services 4 Oxygen Units 5 Units of Blood 6 Allergy Tests 7 Lab Tests 8 Minutes of Anesthesia	Value must be valid (see list of valid values in the Field Contents column).	
P034	Units of Service	3	A	195	197	95%	Quantity of services or number of units for a service or minutes of anesthesia.	Report as whole number rounded to nearest whole value. For instance, if the value is "16.6," report 17.	Must be an integer.	
P035	Procedure Code	6	A	198	203	95%	Describes the health care service provided (CPT-4 or HCPCS)		Value must be a valid CPT or HCPCS code.	
P036	Modifier I	2	A	204	205		Discriminate code used by practitioners to distinguish that a health care service has been altered [by a specific condition] but not changed in definition or code. A modifier is added as a suffix to a procedure code field.	<p>HCPCS accepts national standard modifiers approved by the American Medical Association as published in the 2008 Current Procedure Terminology. Modifiers approved for Hospital Outpatient use: Level I (CPT) and Level II (HCPCS/National) modifiers.</p> <p>Nurse Anesthetist services are to be reported using the following Level II (HCPCS) modifiers:</p> <ul style="list-style-type: none"> · QX – Nurse Anesthetist service; under supervision of a doctor · QZ – Nurse Anesthetist service; w/o the supervision of a doctor 	Value must be a valid modifier applicable to the procedure code.	
P037	Modifier II	2	A	206	207		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
P038	Servicing Practitioner ID	11	A	208	218	100%	Payor-specific identifier for the practitioner rendering health care service(s).		Must be populated with values that are not unknown (entirely 0s and 9s).	
P039	Billed Charge	9	N	219	227	100%	A practitioner's billed charges rounded to whole dollars.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
P040	Allowed Amount	9	N	228	236	100%	Maximum amount contractually allowed. This is generally equal to the sum of patient liability and payor reimbursement. For payors that participate in the sale of ACA compliant health insurance products on or off the Maryland Health Benefit Exchange (MHBE), membership and allowed claims data in the MCDB must be consistent with the membership and allowed claims data submitted by your company's Actuarial Pricing/Rating department to the Maryland Insurance Administration (MIA) via Actuarial Memorandums and rate filings. The Individual and Small Group markets (Non-Grandfathered Health Plans only) are affected by this MCDB v. MIA data reconciliation and will result in MCDB data resubmissions if discrepancies in the excess of 2.5% exist.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	Modified description for clarity.
P041	Reimbursement Amount	9	N	237	245	100%	Amount paid to Employer Tax ID # of rendering physician as listed on claim.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
P042	Date of Enrollment	8	N	246	253		The first day of the reporting period the patient is in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient not enrolled at start of reporting period, but enrolled during reporting period. This field is optional, but must be populated in the Eligibility file.	Must be a valid date value.	
P043	Date of Disenrollment	8	N	254	261		The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD If patient is still enrolled on the last day of the reporting period, enter 20991231. If patient disenrolled before end of reporting period enter date disenrolled. This field is optional, but must be populated in the Eligibility file.	Must be a valid date value or left blank.	
P044	Patient Deductible	9	N	262	270	100%	The fixed amount that the patient must pay for covered medical services before benefits are payable.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
P045	Patient Coinsurance or Patient Co-payment	9	N	271	279	100%	The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
P046	Other Patient Obligations	9	N	280	288	100%	Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payor reimbursement), non-covered services, or penalties.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
P047	Plan Liability	1	A	289	289		Indicates if insurer is at risk for the patient's service use or the insurer is simply paying claims as Administrative Services Only (ASO)	1 Risk (under Maryland contract) 2 Risk (under non-Maryland contract) 3 ASO (employer self-insured, under Maryland contract) 4 ASO (employer self-insured, under non-Maryland contract) This field is optional, but must be populated in the Eligibility file.	Value must be valid (see list of valid values in the Field Contents column).	
P048	Servicing Practitioner Individual National Provider Identifier (NPI) Number	10	A	290	299	100%	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf	Value must be a valid NPI number.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
P049	Practitioner National Provider Identifier (NPI) Number used for Billing	10	A	300	309	100%	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner or an organization for billing purposes.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf	Value must be a valid NPI number.	
P050	Product Type	1	A	310	310		Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits).	This field is optional, but must be populated in the Eligibility file.		
P051	Payor ID Number	4	A	311	314	100%	Payor assigned submission identification number.		Value must match payor's assigned identification number. Value must be identical in all records.	
P052	Source System	1	A	315	315	100%	Identify the source system (platforms or business units) from which the data was obtained by using an alphabet letter (A, B, C, D, etc...) Please ensure that the source system letter used is consistent from quarter to quarter, as well as with the source system letter indicated on the MCDB Portal.	A – Z. If only submitted for one source system, default is A.	Value must be valid (see list of valid values in the Field Contents column). Must be consistent with previous quarter.	
P053	Assignment of Benefits	1	A	316	316	100%	For out-of-network services please provide information on whether or not the patient assigned benefits to the servicing physician for an out-of-network service.	0 No, Assignment of Benefits not accepted and Practitioner Not in Network 1 Yes, Assignment of Benefits Accepted and Practitioner Not in Network 2 N/A, Practitioner is In Network 9 Unknown	Value must be valid (see list of valid values in the Field Contents column).	
P054	Diagnosis Code Indicator	1	A	317	317		Indicates the volume of the International Classification of Diseases, Clinical Modification system used in assigning codes to diagnoses.	1 ICD-9-CM 2 ICD-10-CM 3 Missing/Unknown	Value must be valid (see list of valid values in the Field Contents column).	
P055	CPT Category II Code 1	5	A	318	322		Provide any applicable CPT Category II codes.		Value must be a valid CPT Category II code.	
P056	CPT Category II Code 2	5	A	323	327		See comment under CPT Category II Code 1		Value must be a valid CPT Category II code.	
P057	CPT Category II Code 3	5	A	328	332		See comment under CPT Category II Code 1		Value must be a valid CPT Category II code.	
P058	CPT Category II Code 4	5	A	333	337		See comment under CPT Category II Code 1		Value must be a valid CPT Category II code.	
P059	CPT Category II Code 5	5	A	338	342		See comment under CPT Category II Code 1		Value must be a valid CPT Category II code.	
P060	Reporting Quarter	1	A	343	343	100%	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31	Value must match the current reporting quarter.	
P061	Claim Adjudication Date	8	N	344	351	100%	The date that the claim was adjudicated.	CCYYMMDD	Must be a valid date value.	
P062	Claim Line Number	4	A	352	355	100%	Line number for the service within a claim.	The first line is 1 and subsequent lines are incremented by 1	Must be an integer.	
P063	Version Number	4	A	356	359	100%	Version number of this claim service line. The version number begins with 1 and is incremented by 1 for each subsequent version of that service line.		Must be an integer.	
P064	Claim Line Type	1	A	360	360	100%	Code Indicating Type of Record. Example: Original, Void, Replacement, Back Out, Amendment	O Original V Void R Replacement B Back Out A Amendment	Value must be valid (see list of valid values in the Field Contents column).	
P065	Former Claim Number	23	A	361	383	30%	Former claims control number or claims control number used in the original claim that corresponds to this claim line.	Must be different to the claims control number reported under field # 15	Must be at least 2 characters long. Must be populated with values that are not unknown (entirely 0s and 9s).	
P066	Flag for Former Claim Number Use	1	A	384	384	100%	Code Indicating the use of former claims control number	1 Former claims number not used-claim does not change 2 Former claims number not used-new claim is generated 3 Former claims number used		

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
P067	NDC Number	11	A	385	395		National Drug Code 11 digit number.	<p>This field is filled when provider-administered drugs are available on a professional claim.</p> <p>Please ensure leading zeroes are not dropped for NDCs beginning with 0s.</p> <p>Expected to be populated when provider-administered drugs are involved in a claim.</p>	Value must be a valid NDC number.	
P068	Drug Quantity	5	N	396	400		Number of units of medication dispensed.	<p>Expected to be populated when provider-administered drugs are involved in a claim.</p>	Value must be rounded to the nearest unit	

PHARMACY DATA REPORT SUBMISSION

This report details all prescription drug encounters for your enrollees for the quarterly reporting period designated – First Quarter: Claims paid from January 1, 2017 through March 31, 2017; Second Quarter: Claims paid from April 1, 2017 through June 30, 2017; Third Quarter: Claims paid from July 1, 2017 through September 30, 2017; and Fourth Quarter: Claims paid from October 1, 2017 through December 31, 2017. Please provide information on all pharmacy services provided to applicable insureds whether the services were provided by a pharmacy located in-State or out-of-State. Do not include pharmacy supplies or prosthetics.

COMAR 10.25.06 specifies the Pharmacy Data Report be submitted separately from the Professional Services Data Report.

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
R001	Record Identifier	1	A	1	1	100%	The value is 2	2 Pharmacy Services	In the Pharmacy Services file, this field must be 2.	
R002	Encrypted Enrollee's IdentifierP	12	A	2	13	100%	Patient's unique identification number assigned by payor and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Eligibility, Pharmacy Claims, Institutional Services, and Dental Services Files) If the encryption algorithm for Patient ID changes, please contact MHCC before submitting.	Cannot be entirely unknown values (0s, 1s, and 9s). Must be at least 3 characters long. Must be consistent with previous quarter i.e. the same patient is identified by the same ID across payers. Must be unique for each beneficiary.	
R003	Encrypted Enrollee's IdentifierU	12	A	14	25	100%	Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual. Leave UUID blank if it is not generated by the UUID software.	Cannot be entirely unknown values (0s, 1s, and 9s). Must be 12 characters long. Alphabetical characters must be lower-case as generated by the UUID application. Must be consistent with previous quarter i.e. the same patient is identified by the same ID across payers.	
R004	Enrollee Sex	1	A	26	26	99%	Sex of the enrollee.	1 Male 2 Female	Value must be valid (see list of valid values in the Field Contents column).	
R005	Enrollee Zip Code of Residence +4 digit add-on code	10	A	27	36	99%	Zip code of enrollee's residence.	5-digit US Postal Service code plus 4-digit add-on code. If 4-digit add on code is available, please use the format "XXXX-XXXX". If 4-digit add-on code is missing, please use the format of either "XXXX-0000" or "XXXX".	Value must be a valid US postal code. If any of the 4-digit add-on values are populated, they must all be populated. If the 4-digit add-on values are populated, the 6th digit must be a hyphen.	
R006	Enrollee Year and Month of Birth	8	N	37	44	100%	Date of enrollee's birth using 00 instead of day.	CCYYMM00	Year and month of birth must be valid.	
R007	Pharmacy NCPDP Number	7	A	45	51	100%	Unique 7 digit number assigned by the National Council for Prescription Drug Program (NCPDP).	Use Pharmacy NPI Number if Pharmacy NCPDP Number is unavailable (waiver required).	Value must be shorter than or equal to 7 characters unless a Pharmacy NPI has been provided instead. In this case, it must be a valid value.	
R008	Pharmacy Zip Code +4digit add-on code	10	A	52	61	95%	Zip code of pharmacy where prescription was filled and dispensed.	5-digit US Postal Service code plus 4-digit add-on code. If 4-digit add on code is available, please use the format "XXXX-XXXX". If 4-digit add-on code is missing, please use the format of either "XXXX-0000" or "XXXX".	Value must be a valid US postal code. If any of the 4-digit add-on values are populated, they must all be populated. If the 4-digit add-on values are populated, the 6th digit must be a hyphen.	
R009	Practitioner DEA Number	11	A	62	72	100%	Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act.	Same as DEA Number in Provider File. Only required if NPI has not been reported (waiver required).	The first two characters must be letters. Value must be valid according to the check equation.	
R010	Fill Number	2	A	73	74	100%	The code used to indicate if the prescription is an original prescription or a refill. Use '01' for all refills if the specific number of the prescription refill is not available.	00 New prescription/Original 01 – 99 Refill number	Value must be valid (see list of valid values in the Field Contents column).	
R011	NDC Number	11	A	75	85	100%	National Drug Code 11 digit number.	Please ensure leading zeroes are not dropped for NDCs beginning with 0s.	Value must be a valid NDC number.	
R012	Drug Compound	1	A	86	86		Indicates a mix of drugs to form a compound medication.	1 Non-compound 2 Compound	Value must be valid (see list of valid values in the Field Contents column).	
R013	Drug Quantity	5	N	87	91	99%	Number of units of medication dispensed.		Value must be a nonzero integer.	
R014	Drug Supply	3	N	92	94	99%	Estimated number of days of dispensed supply.		Value must be a nonzero integer.	
R015	Date Filled	8	N	95	102	100%	Date prescription was filled.	CCYYMMDD	Must be a valid date value.	
R016	Date Prescription Written	8	N	103	110		Date prescription was written.	CCYYMMDD	Must be a valid date value.	
R017	Billed Charge	9	N	111	119	100%	Retail amount for drug including dispensing fees and administrative costs.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
R018	Reimbursement Amount	9	N	120	128	100%	Amount paid to the pharmacy by payor. Do not include patient copayment or sales tax.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
R019	Prescription Claim Control Number	15	A	129	143	100%	Internal payor claim number used for tracking.		Must be at least 2 characters long. Must be populated with values that are not unknown (entirely 0s and 9s).	
R020	Prescription Claim Paid Date	8	N	144	151	100%	The date that the claim was paid. This date should agree with the paid date the Finance and Actuarial department is using in your organization. If there is a lag between the time a claim is authorized and paid, please contact MHCC for advice on which date field to use.	CCYYMMDD	Must be a valid date value.	
R021	Prescribing Practitioner Individual National Provider Identifier (NPI) Number	10	A	152	161	100%	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf	Value must be a valid NPI number.	
R022	Patient Deductible	9	N	162	170	100%	The fixed amount that the patient must pay for covered pharmacy services before benefits are payable.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
R023	Patient Coinsurance or Patient Co-payment	9	N	171	179	100%	The specified amount or percentage the patient is required to contribute towards covered pharmacy services after any applicable deductible.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
R024	Other Patient Obligations	9	N	180	188	100%	Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for non-formulary drugs, non-covered pharmacy services, or penalties.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
R025	Date of Enrollment	8	N	189	196		The first day of the reporting period the patient is in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient not enrolled at start of reporting period, but enrolled during reporting period. This field is optional, but must be populated in the Eligibility file.	Must be a valid date value.	
R026	Date of Disenrollment	8	N	197	204		The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD If patient is still enrolled on the last day of the reporting period, enter 20991231. If patient disenrolled before end of reporting period enter date disenrolled. This field is optional, but must be populated in the Eligibility file.	Must be a valid date value or left blank.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
R027	Source of Processing	1	A	205	205	100%	The source processing the pharmacy claim.	<ul style="list-style-type: none"> 1 Processed Internally by Payor 2 Argus Health Systems, Inc. 3 Caremark, LLC 4 Catalyst Rx, Inc. 5 Envision Pharmaceutical Services, Inc. 6 Express Scripts, Inc. 7 Medco Health, LLC 8 National Employee Benefit Companies, Inc. 9 NextRx Services, Inc. A Atlantic Prescription Services, LLC B Benecard Services, Inc. C BioScrip PBM Services, LLC D Futurescripts, LLC E Health E Systems F HealthTran, LLC G Innoviant, Inc. H MaxorPlus I Medical Security Card Company J MedImpact Healthcare Systems, Inc. K MemberHealth, LLC L PharmaCare Management Services, LLC M Prime Therapeutics, LLC N Progressive Medical, Inc. O RxAmerica, LLC P RxSolutions, Inc. Q Scrip World, LLC R Tmesys, Inc. S WellDyne, Inc. 	Value must be valid (see list of valid values in the Field Contents column).	
R028	Payor ID Number	4	A	206	209	100%	Payor assigned submission identification number.		Value must match payor's assigned identification number. Value must be identical in all records.	
R029	Source System	1	A	210	210	100%	Identify the source system (platforms or business units) <i>from which the data was obtained</i> by using an alphabet letter (A, B, C, D, etc...) Please ensure that the source system letter used is consistent from quarter to quarter, as well as with the source system letter indicated on the MCDB Portal.	A – Z. If only submitted for one source system, default is A.	Value must be valid (see list of valid values in the Field Contents column). Must be consistent with previous quarter.	
R030	Reporting Quarter	1	A	211	211	100%	Indicate the quarter number for which the data is being submitted	<ul style="list-style-type: none"> 1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31 	Value must match the current reporting quarter.	
R031	Pharmacy NPI Number	10	A	212	221	100%	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner. This is the NPI of the dispensing pharmacy	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf	Value must be a valid NPI number.	
R032	Prescribing Provider ID	11	A	222	232	100%	Payor-specific identifier (internal ID) for the prescribing practitioner.	Must link to the practitioner ID on the Provider Directory	Must be populated with values that are not unknown (entirely 0s and 9s).	
R033	Claim Adjudication Date	8	N	233	240	100%	The date that the claim was adjudicated.	CCYYMMDD	Must be a valid date value.	
R034	Claim Line Number	4	A	241	244	100%	Line number for the service within a claim.	The first line is 1 and subsequent lines are incremented by 1	Must be an integer.	
R035	Version Number	4	A	245	248	100%	Version number of this claim service line. The version number begins with 1 and is incremented by 1 for each subsequent version of that service line		Must be an integer.	
R036	Claim Line Type	1	A	249	249	100%	Code Indicating Type of Record. Example: Original, Void, Replacement, Back Out, Amendment	<ul style="list-style-type: none"> O Original V Void R Replacement B Back Out A Amendment 	Value must be valid (see list of valid values in the Field Contents column).	
R037	Former Prescription Claim Number	23	A	250	272	30%	Former claims control number or claims control number used in the original claim that corresponds to this claim line.	Must be different to the claims control number reported under field # 19	Must be at least 2 characters long. Must be populated with values that are not unknown (entirely 0s and 9s).	

INSTITUTIONAL SERVICES DATA REPORT SUBMISSION

This report details all institutional health care services (including hospital inpatient, outpatient, and emergency department services) provided to your enrollees quarterly reporting period designated – First Quarter: Claims paid from January 1, 2017 through March 31, 2017; Second Quarter: Claims paid from April 1, 2017 through June 30, 2017; Third Quarter: Claims paid from July 1, 2017 through September 30, 2017; and Fourth Quarter: Claims paid from October 1, 2017 through December 31, 2017. Please provide information on all institutional services provided to applicable insureds whether by a health care facility located in-State or out-of-State.

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

Level File format. For inpatient facility (hospital and non-hospital), each line would be defined by revenue code. Each line will have one revenue code. However, each revenue code can have more than one procedure or diagnosis code. For inpatient claims, all ICD procedure codes present on the same claim should be replicated for each line of the same claim.

For outpatient facility (hospital and non-hospital), each line would be defined by revenue code or CPT code, each in its own respective field. Each line will have one revenue code or at least one CPT code. If a revenue code is not available or applicable, the field should be left blank. However, such lines must be identified with at least a CPT code in the principal procedure code.

All diagnosis codes should be repeated on all lines of a claim, regardless of the type of facility.

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I001	Record Identifier	1	A	1	1	100%	The value is 4	4 Institutional Services	In the Institutional Services file, this field must be 4.	
I002	Encrypted Enrollee's IdentifierP	12	A	2	13	100%	Enrollee's unique identification number assigned by payor and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Eligibility, Pharmacy Claims, Institutional Services, and Dental Services Files) If the encryption algorithm for Patient ID changes, please contact MHCC before submitting.	Cannot be entirely unknown values (0s, 1s, and 9s). Must be at least 3 characters long. Must be consistent with previous quarter i.e. the same patient is identified by the same ID across payers. Must be unique for each beneficiary.	
I003	Encrypted Enrollee's IdentifierU	12	A	14	25	100%	Enrollee's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual. Leave UUID blank if it is not generated by the UUID software.	Cannot be entirely unknown values (0s, 1s, and 9s). Must be 12 characters long. Alphabetical characters must be lower-case as generated by the UUID application. Must be consistent with previous quarter i.e. the same patient is identified by the same ID across payers.	
I004	Enrollee Year and Month of Birth	8	N	26	33	100%	Date of enrollee's birth using 00 instead of day.	CCYYMM00	Year and month of birth must be valid.	
I005	Enrollee Sex	1	A	34	34	99%	Sex of the enrollee.	1 Male 2 Female	Value must match value found in field contents.	
I006	Enrollee Zip Code of Residence +4 digit add-on code	10	A	35	44	99%	Zip code of enrollee's residence.	5-digit US Postal Service code plus 4-digit add-on code. If 4-digit add on code is available, please use the format "XXXXX-XXXX". If 4-digit add-on code is missing, please use the format of either "XXXXX-0000" or "XXXXX".	Value must be a valid US postal code. If any of the 4-digit add-on values are populated, they must all be populated. If the 4-digit add-on values are populated, the 6th digit must be a hyphen.	
I007	Date of Enrollment	8	N	45	52		The start date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient not enrolled at start of reporting period, but enrolled during reporting period. This field is optional, but must be populated in the Eligibility file.	Must be a valid date value.	
I008	Date of Disenrollment	8	N	53	60		The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD If patient is still enrolled on the last day of the reporting period, enter 20991231. If patient disenrolled before end of reporting period enter date disenrolled. This field is optional, but must be populated in the Eligibility file.	Must be a valid date value or left blank.	
I009	Hospital/Facility Federal Tax ID	9	A	61	69	100%	Federal Employer Tax ID of the facility receiving payment for care.		Must be 9 characters long. Value must be a valid federal tax ID.	
I010	Hospital/Facility National Provider Identifier (NPI) Number	10	A	70	79	100%	Federal Identifier assigned by the federal government for use in all HIPAA transactions to an organization for billing purposes.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf	Value must be a valid NPI number.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I011	Hospital/Facility Medicare Provider Number	6	A	80	85		Federal identifier assigned by the federal government for use in all Medicare transactions to an organization for billing purposes.	Six (6) digits	Value must be populated. Must be populated with values that are not unknown (entirely 0s and 9s).	
I012	Hospital/Facility Participating Provider Flag	1	A	86	86	95%	Indicates if the service was provided at a hospital/facility that participates in the payor's network.	1 Participating 2 Non-Participating 3 Unknown/Not Coded 9 No Network for this Plan	Value must be valid (see list of valid values in the Field Contents column).	
I013	Claim Control Number	23	A	87	109	100%	Internal payor claim number used for tracking.	This is the key to summarizing service detail to claim level & must be included on each record.	Must be at least 2 characters long. Must be populated with values that are not unknown (entirely 0s and 9s).	
I014	Claim Paid Date	8	N	110	117	100%	The date that the claim was paid. This date should agree with the paid date the Finance and Actuarial department is using in your organization. If there is a lag between the time a claim is authorized and paid, please contact MHCC for advice on which date field to use.	CCYYMMDD	Must be a valid date value.	
I015	Record Type	2	A	118	119		Identifies the type of facility or department in a facility where the service was provided. This date correspond to the	10 Hospital Inpatient – Undefined 11 Hospital Inpatient – Acute care 12 Hospital Inpatient – Children’s Hospital 13 Hospital Inpatient – Mental health or Substance abuse 14 Hospital Inpatient – Rehabilitation, Long term care, SNF stay 20 Hospital Outpatient – Undefined 21 Hospital Outpatient – Ambulatory Surgery 22 Hospital Outpatient – Emergency Room 23 Hospital Outpatient – Other 30 Non-Hospital Facility	Value must be valid (see list of valid values in the Field Contents column).	
I016	Type of Admission	1	A	120	120	95%	Applies only to hospital inpatient records. All other record types code "0".	1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma Center 6 Reserved for National Assignment 7 Reserved for National Assignment 8 Reserved for National Assignment 9 Information Not Available 0 Not a hospital inpatient record	Value must be valid (see list of valid values in the Field Contents column).	
I017	Point of Origin for Admission or Visit	1	A	121	121	95%	Applies only to hospital inpatient records. All other record types code "0". (Note: Assign the code where the patient originated from before presenting to the health care facility.)	For Newborns (Type of Admission = 4) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Not used 5 Born inside this hospital 6 Born outside of this hospital 9 Information not available Admissions other than Newborn 1 Non-Health Facility Point of Origin 2 Clinic or Physician’s Office 3 Reserved for national assignment 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 8 Court/Law Enforcement	Value must be valid (see list of valid values in the Field Contents column).	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I018	Patient Discharge Status	2	A	122	123	95%	Indicates the disposition of the patient at discharge. Applies only to hospital inpatient records. All other record types code "00".	01 Routine (home or self care) 02 Another Short-term Hospital 03 Skilled Nursing Facility (SNF) 04 Intermediate care facility (ICF) 05 Another type of facility (includes rehab facility, hospice, etc.) 06 Home Health Care (HHC) 07 Against medical advice 09 Admitted as an inpatient to this hospital 20 Expired (Religious) 30 Still patient 40 Expired at home (Hospice claims) 41 Expired in a medical facility(Hospice claims only) 42 Expired - place unknown (Hospice claims only) 43 Federal hospital 50 Hospice - home 51 Hospice - medical facility 61 Hospital-based Medicare approved swing bed 62 IP Rehab facility (not hospital) 63 Discharged/transferred to long term care hospital 65 Psychiatric hospital 66 Transferred to a CAH 69 Designated disaster alternative care site 70 Another type of health care institution 81 Home or self-care(planned readmission) 82 Short term general hospital for IP care 83 Skilled nursing facility (SNF) 84 Facility providing custodial or supportive care 85 Designated cancer center or children's hospital 86 Home Health Care (HHC) 87 Court/Law Enforcement 88 Federal health care facility 89 Hospital-based Medicare approved swing bed 90 Inpatient rehabilitation facility (IRF) 91 Certified long term care hospital(LTCH) 92 Nursing facility certified under Medicaid 93 Psychiatric hospital/distinct part unit of a hospital	Value must be valid (see list of valid values in the Field Contents column).	
I019	Date of Admission or Start of Service	8	N	124	131	99%	First date of service for a procedure in this line item.	CCYYMMDD	Must be a valid date value.	
I020	Date of Discharge or End of Service	8	A	132	139	99%*	Last date of service for a procedure in this line item.	CCYYMMDD If the Date of Discharge or End of Service (I020) is not reported, then assume that the Date of Admission or Start of Service (I019) and the Date of Discharge or End of Service are the same	Must be a valid date value.	
I021	Diagnosis Code Indicator	1	A	140	140		Indicates the volume of the International Classification of Diseases, Clinical Modification system used in assigning codes to diagnoses.	1 ICD-9-CM 2 ICD-10-CM 3 Missing/Unknown	Value must be valid (see list of valid values in the Field Contents column).	
I022	Primary Diagnosis	7	A	141	147	99%	The primary ICD-9-CM or ICD-10-CM Diagnosis Code followed by a secondary diagnosis (up to 29 codes), if applicable at the time of service.	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I023	Primary Diagnosis Present on Admission	1	A	148	148		Primary Diagnosis present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I024	Other Diagnosis Code 1	7	A	149	155		ICD-9-CM/ICD-10-CM Diagnosis Code 1	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I025	Other Diagnosis Code 1 present on Admission 1	1	A	156	156		Diagnosis Code 1 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I026	Other Diagnosis Code 2	7	A	157	163		ICD-9-CM/ICD-10-CM Diagnosis Code 2	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I027	Other Diagnosis Code 2 present on Admission 2	1	A	164	164		Diagnosis Code 2 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I028	Other Diagnosis Code 3	7	A	165	171		ICD-9-CM/ICD-10-CM Diagnosis Code 3	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I029	Other Diagnosis Code 3 present on Admission 3	1	A	172	172		Diagnosis Code 3 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I030	Other Diagnosis Code 4	7	A	173	179		ICD-9-CM/ICD-10-CM Diagnosis Code 4	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I031	Other Diagnosis Code 4 present on Admission 4	1	A	180	180		Diagnosis Code 4 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I032	Other Diagnosis Code 5	7	A	181	187		ICD-9-CM/ICD-10-CM Diagnosis Code 5	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I033	Other Diagnosis Code 5 present on Admission 5	1	A	188	188		Diagnosis Code 5 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I034	Other Diagnosis Code 6	7	A	189	195		ICD-9-CM/ICD-10-CM Diagnosis Code 6	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I035	Other Diagnosis Code 6 present on Admission 6	1	A	196	196		Diagnosis Code 6 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I036	Other Diagnosis Code 7	7	A	197	203		ICD-9-CM/ICD-10-CM Diagnosis Code 7	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I037	Other Diagnosis Code 7 present on Admission 7	1	A	204	204		Diagnosis Code 7 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I038	Other Diagnosis Code 8	7	A	205	211		ICD-9-CM/ICD-10-CM Diagnosis Code 8	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I039	Other Diagnosis Code 8 present on Admission 8	1	A	212	212		Diagnosis Code 8 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I040	Other Diagnosis Code 9	7	A	213	219		ICD-9-CM/ICD-10-CM Diagnosis Code 9	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I041	Other Diagnosis Code 9 present on Admission 9	1	A	220	220		Diagnosis Code 9 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I042	Other Diagnosis Code 10	7	A	221	227		ICD-9-CM/ICD-10-CM Diagnosis Code 10	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I043	Other Diagnosis Code 10 present on Admission 10	1	A	228	228		Diagnosis Code 10 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I044	Other Diagnosis Code 11	7	A	229	235		ICD-9-CM/ICD-10-CM Diagnosis Code 11	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I045	Other Diagnosis Code 11 present on Admission 11	1	A	236	236		Diagnosis Code 11 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I046	Other Diagnosis Code 12	7	A	237	243		ICD-9-CM/ICD-10-CM Diagnosis Code 12	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I047	Other Diagnosis Code 12 present on Admission 12	1	A	244	244		Diagnosis Code 12 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I048	Other Diagnosis Code 13	7	A	245	251		ICD-9-CM/ICD-10-CM Diagnosis Code 13	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I049	Other Diagnosis Code 13 present on Admission 13	1	A	252	252		Diagnosis Code 13 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I050	Other Diagnosis Code 14	7	A	253	259		ICD-9-CM/ICD-10-CM Diagnosis Code 14	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I051	Other Diagnosis Code 14 present on Admission 14	1	A	260	260		Diagnosis Code 14 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I052	Other Diagnosis Code 15	7	A	261	267		ICD-9-CM/ICD-10-CM Diagnosis Code 15	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I053	Other Diagnosis Code 15 present on Admission 15	1	A	268	268		Diagnosis Code 15 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I054	Other Diagnosis Code 16	7	A	269	275		ICD-9-CM/ICD-10-CM Diagnosis Code 16	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I055	Other Diagnosis Code 16 present on Admission 16	1	A	276	276		Diagnosis Code 16 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I056	Other Diagnosis Code 17	7	A	277	283		ICD-9-CM/ICD-10-CM Diagnosis Code 17	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I057	Other Diagnosis Code 17 present on Admission 17	1	A	284	284		Diagnosis Code 17 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I058	Other Diagnosis Code 18	7	A	285	291		ICD-9-CM/ICD-10-CM Diagnosis Code 18	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I059	Other Diagnosis Code 18 present on Admission 18	1	A	292	292		Diagnosis Code 18 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I060	Other Diagnosis Code 19	7	A	293	299		ICD-9-CM/ICD-10-CM Diagnosis Code 19	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I061	Other Diagnosis Code 19 present on Admission 19	1	A	300	300		Diagnosis Code 19 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I062	Other Diagnosis Code 20	7	A	301	307		ICD-9-CM/ICD-10-CM Diagnosis Code 20	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I063	Other Diagnosis Code 20 present on Admission 20	1	A	308	308		Diagnosis Code 20 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I064	Other Diagnosis Code 21	7	A	309	315		ICD-9-CM/ICD-10-CM Diagnosis Code 21	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I065	Other Diagnosis Code 21 present on Admission 21	1	A	316	316		Diagnosis Code 21 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I066	Other Diagnosis Code 22	7	A	317	323		ICD-9-CM/ICD-10-CM Diagnosis Code 22	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I067	Other Diagnosis Code 22 present on Admission 22	1	A	324	324		Diagnosis Code 22 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I068	Other Diagnosis Code 23	7	A	325	331		ICD-9-CM/ICD-10-CM Diagnosis Code 23	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I069	Other Diagnosis Code 23 present on Admission 23	1	A	332	332		Diagnosis Code 23 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I070	Other Diagnosis Code 24	7	A	333	339		ICD-9-CM/ICD-10-CM Diagnosis Code 24	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I071	Other Diagnosis Code 24 present on Admission 24	1	A	340	340		Diagnosis Code 24 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I072	Other Diagnosis Code 25	7	A	341	347		ICD-9-CM/ICD-10-CM Diagnosis Code 25	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I073	Other Diagnosis Code 25 present on Admission 25	1	A	348	348		Diagnosis Code 25 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I074	Other Diagnosis Code 26	7	A	349	355		ICD-9-CM/ICD-10-CM Diagnosis Code 26	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I075	Other Diagnosis Code 26 present on Admission 26	1	A	356	356		Diagnosis Code 26 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I076	Other Diagnosis Code 27	7	A	357	363		ICD-9-CM/ICD-10-CM Diagnosis Code 27	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I077	Other Diagnosis Code 27 present on Admission 27	1	A	364	364		Diagnosis Code 27 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I078	Other Diagnosis Code 28	7	A	365	371		ICD-9-CM/ICD-10-CM Diagnosis Code 28	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I079	Other Diagnosis Code 28 present on Admission 28	1	A	372	372		Diagnosis Code 28 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I080	Other Diagnosis Code 29	7	A	373	379		ICD-9-CM/ICD-10-CM Diagnosis Code 29	Remove embedded decimal points.	Value must be a valid ICD-9-CM/ICD-10-CM diagnosis code. Must not include embedded decimal points.	
I081	Other Diagnosis Code 29 present on Admission 29	1	A	380	380		Diagnosis Code 29 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting 0 - Not a hospital inpatient record.	Value must be valid (see list of valid values in the Field Contents column).	
I082	Attending Practitioner Individual National Provider Identifier (NPI) Number	10	A	381	390	95%	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	The physician responsible for the patient's medical care and treatment. If outpatient or emergency room, this data element refers to the Practitioner treating patient at time of service.	Value must be a valid NPI number.	
I083	Operating Practitioner Individual National Provider Identifier (NPI) Number	10	A	391	400		Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	This element identifies the operating physician who performed the surgical procedure.	Value must be a valid NPI number.	
I084	Procedure Code Indicator	1	A	401	401		Indicates the classification used in assigning codes to procedures.	1 ICD-9-CM 2 ICD-10-PCS 3 CPT Code/HCPCS	Value must be valid (see list of valid values in the Field Contents column).	
I085	Principal Procedure Code 1	7	A	402	408		The principal health care service provided, followed by a secondary procedure (up to 15 codes), if applicable at the time of service.	Remove embedded decimal points. CPT Codes are required on all non-inpatient claims (ER, clinic, outpatient), but will allow ICD-9-CM or ICD-10-CM Codes for inpatient claims. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code).	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I086	Procedure Code 1 Modifier I	2	A	409	410		Discriminate code used by practitioners to distinguish that a health care service has been altered [by a specific condition] but not changed in definition or code. A modifier is added as a suffix to a procedure code field.	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I087	Procedure Code 1 Modifier II	2	A	411	412		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I088	Other Procedure Code 2	7	A	413	419			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code).	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I089	Procedure Code 2 Modifier I	2	A	420	421		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I090	Procedure Code 2 Modifier II	2	A	422	423		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I091	Other Procedure Code 3	7	A	424	430			Remove embedded decimal points. CPT Codes are required on all non-inpatient claims (ER, clinic, outpatient), but will allow ICD-9-CM or ICD-10-CM Codes for inpatient claims. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code).	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I092	Procedure Code 3 Modifier I	2	A	431	432		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I093	Procedure Code 3 Modifier II	2	A	433	434		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I094	Other Procedure Code 4	7	A	435	441			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code).	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I095	Procedure Code 4 Modifier I	2	A	442	443		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I096	Procedure Code 4 Modifier II	2	A	444	445		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I097	Other Procedure Code 5	7	A	446	452			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code).	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I098	Procedure Code 5 Modifier I	2	A	453	454		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I099	Procedure Code 5 Modifier II	2	A	455	456		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I100	Other Procedure Code 6	7	A	457	463			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code).	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I101	Procedure Code 6 Modifier I	2	A	464	465		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I102	Procedure Code 6 Modifier II	2	A	466	467		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I103	Other Procedure Code 7	7	A	468	474			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code).	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I104	Procedure Code 7 Modifier I	2	A	475	476		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I105	Procedure Code 7 Modifier II	2	A	477	478		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I106	Other Procedure Code 8	7	A	479	485			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code)	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I107	Procedure Code 8 Modifier I	2	A	486	487		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I108	Procedure Code 8 Modifier II	2	A	488	489		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I109	Other Procedure Code 9	7	A	490	496			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code)	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I110	Procedure Code 9 Modifier I	2	A	497	498		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I111	Procedure Code 9 Modifier II	2	A	499	500		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I112	Other Procedure Code 10	7	A	501	507			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code)	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I113	Procedure Code 10 Modifier I	2	A	508	509		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I114	Procedure Code 10 Modifier II	2	A	510	511		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I115	Other Procedure Code 11	7	A	512	518			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code)	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I116	Procedure Code 11 Modifier I	2	A	519	520		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I117	Procedure Code 11 Modifier II	2	A	521	522		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I118	Other Procedure Code 12	7	A	523	529			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code)	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I119	Procedure Code 12 Modifier I	2	A	530	531		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I120	Procedure Code 12 Modifier II	2	A	532	533		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I121	Other Procedure Code 13	7	A	534	540			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code)	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I122	Procedure Code 13 Modifier I	2	A	541	542		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I123	Procedure Code 13 Modifier II	2	A	543	544		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I124	Other Procedure Code 14	7	A	545	551			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code)	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I125	Procedure Code 14 Modifier I	2	A	552	553		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I126	Procedure Code 14 Modifier II	2	A	554	555		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I127	Other Procedure Code 15	7	A	556	562			Remove embedded decimal points. Note: For Inpatient Facility (hospital and non-hospital) ICD Procedure codes must be repeated for all lines of the claim if necessary. Revenue code defines a claim line for inpatient. For Outpatient Facility (hospital and non-hospital) Revenue code (where applicable) or CPT code defines a claim line (i.e. an independent line for each revenue code or procedure code)	Value must be a valid CPT or HCPCS code on non-inpatient claims. Value must be a valid CPT, HCPCS, ICD-9-CM, or ICD-10-PCS code on inpatient claims.	
I128	Procedure Code 15 Modifier I	2	A	563	564		See comment under Procedure Code 1 Modifier I	Modifier applies only to CPT Codes.	Value must be a valid modifier applicable to the procedure code.	
I129	Procedure Code 15 Modifier II	2	A	565	566		Specific to Modifier I.		Value must be a valid modifier applicable to the procedure code.	
I130	Diagnosis Related Groups (DRGs) Number	3	A	567	569		The inpatient classifications based on diagnosis, procedure, age, gender and discharge disposition.		Must be populated.	
I131	DRG Grouper Name	1	A	570	570		The actual DRG Grouper used to produce the DRGs.	1. All Patient Refined (APR) DRGs 2. All Patient Refined DRGs (APR-DRGs) 3. Centers for Medicare & Medicaid Services DRGs (CMS-DRGs) 4. Other Proprietary	Value must be valid (see list of valid values in the Field Contents column).	
I132	DRG Grouper Version	2	A	571	572		Version of DRG Grouper used.			
I133	Billed Charge	9	N	573	581	100%	A provider's billed charges rounded to whole dollars.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
I134	Allowed Amount	9	N	582	590	100%	Maximum amount contractually allowed. This is generally equal to the sum of patient liability and payor reimbursement. For payors that participate in the sale of ACA compliant health insurance products on or off the Maryland Health Benefit Exchange (MHBE), membership and allowed claims data in the MCDB must be consistent with the membership and allowed claims data submitted by your company's Actuarial Pricing/Rating department to the Maryland Insurance Administration (MIA) via Actuarial Memorandums and rate filings. The Individual and Small Group markets (Non-Grandfathered Health Plans only) are affected by this MCDB v. MIA data reconciliation and will result in MCDB data resubmissions if discrepancies in the excess of 2.5% exist.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	Modified description for clarity.
I135	Reimbursement Amount	9	N	591	599	100%	Amount paid by carrier to Tax ID # of provider as listed on claim.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
I136	Total Patient Deductible	9	N	600	608	100%	The fixed amount that the patient must pay for covered medical services/hospital stay before benefits are payable.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I137	Total Patient Coinsurance or Patient Co-payment	9	N	609	617	100%	The specified amount or percentage the patient is required to contribute towards covered medical services/hospital stay after any applicable deductible.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
I138	Total Other Patient Obligations	9	N	618	626	100%	Any patient liability other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payor reimbursement), non-covered services, or penalties.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
I139	Amount Paid by Other Insurance	9	N	627	635	100%	If you are not the primary insurer, report the amount paid by the primary payor.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	Modified field name from "Coordination of Benefits Savings or Other Payor Payments."
I140	Type of Bill	3	A	636	638	99%	UB 04 or UB 92 form 3-digit code = Type of Facility + Bill Classification + Frequency	Type of Facility – 1st 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 – 2nd Digit if 1st Digit = 1-6 1 Inpatient (including Medicare Part A) 2 Inpatient (including 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 – 2nd Digit if 1st Digit = 7 1 Rural Health 2 Hospital-based or Independent Renal Dialysis Center 3 Freestanding Outpatient Rehabilitation Facility (ORF) 4 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 5 Community Mental Health Center 9 Other Bill Classification – 2nd Digit if 1st Digit = 8 1 Hospice (Non-Hospital based) 2 Hospice (Hospital-based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 9 Other Frequency – 3rd Digit 1 Admit through Discharge 2 Interim – First Claim Used 3 Interim – Continuing Claims 4 Interim – Last Claim 5 Late Charge Only 6 Adjustment of Prior Claim 0 No	Value must be valid (see list of valid values in the Field Contents column).	
I141	Patient Covered by Other Insurance Indicator	1	A	639	639	95%	Indicates whether patient has additional insurance coverage.	0 No 1 Yes, other coverage is primary 2 Yes, other coverage is secondary 9 Unknown	Value must be valid (see list of valid values in the Field Contents column).	Added threshold.
I142	Payor ID Number	4	A	640	643	100%	Payor assigned submission identification number.		Value must match payor's assigned identification number. Value must be identical in all records.	
I143	Source System	1	A	644	644	100%	Identify the source system (platforms or business units) from which the data was obtained by using an alphabet letter (A, B, C, D, etc...) Please ensure that the source system letter used is consistent from quarter to quarter, as well as with the source system letter indicated on the MCDB Portal.	A – Z. If only submitted for one source system, default is A.	Value must be valid (see list of valid values in the Field Contents column). Must be consistent with previous quarter.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
I144	Revenue Code	4	A	645	648	100%	Provide the codes used to identify specific accommodation or ancillary charges. Note: For inpatient facility (hospital and non-hospital), each line would be defined by revenue code. Each line will have one revenue code. However, each revenue code can have more than one ICD procedure or diagnosis code. For outpatient facility (hospital and non-hospital), each line would be defined by revenue code or CPT code. Each line will have one revenue code or CPT code. If a revenue code is not available or applicable, a CPT code should be used.		Leading zeros must be included when applicable. Value must be a valid revenue code.	
I167	Reporting Quarter	1	A	649	649	100%	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31	Value must match the current reporting quarter.	
I168	Claim Adjudication Date	8	N	650	657	100%	The date that the claim was adjudicated.	CCYYMMDD	Must be a valid date value.	
I169	Claim Line Number	4	A	658	661	100%	Line number for the service within a claim. Note: For inpatient facility (hospital and non-hospital), each line would be defined by revenue code. Each line will have one revenue code. However, each revenue code can have more than one ICD procedure or diagnosis code. For outpatient facility (hospital and non-hospital), each line would be defined by revenue code or CPT code. Each line will have one revenue code or CPT code. If a revenue code is not available or applicable, a CPT code should be used.	The first line is 1 and subsequent lines are incremented by 1 for each additional service line of a claim. All claims must contain a line 1.	Must be an integer.	
I170	Version Number	4	A	662	665	100%	Version number of this claim service line. The version number begins with 1 and is incremented by 1 for each subsequent version of that service line.		Must be an integer.	
I171	Claim Line Type	1	A	666	666	100%	Code Indicating Type of Record. Example: Original, Void, Replacement, Back Out, Amendment	O Original V Void R Replacement B Back Out A Amendment	Value must be valid (see list of valid values in the Field Contents column).	
I172	Former Claim Number	23	A	667	689	30%	Former claims control number or claims control number used in the original claim that corresponds to this claim line.	Must be different to the claims control number reported under field # 13	Must be at least 2 characters long. Must be populated with values that are not unknown (entirely 0s and 9s).	

DENTAL SERVICES DATA REPORT SUBMISSION

This report details all dental health care services provided to your enrollees for the reporting period designated – First Quarter: Claims paid from January 1, 2017 through March 31, 2017; Second Quarter: Claims paid from April 1, 2017 through June 30, 2017; Third Quarter: Claims paid from July 1, 2017 through September 30, 2017; Fourth Quarter: Claims paid from October 1, 2017 through December 31, 2017.

Please provide information on all dental services provided to Maryland residents whether those services were provided by a practitioner or office facility located in-State or out-of-State.

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
T001	Record Identifier	1	A	1	1	100%	The value is 6	6 Dental Services	In the Dental Services file, this field must be 6.	
T002	Encrypted Enrollee's IdentifierP	12	A	2	13	100%	Enrollee's unique identification number assigned by payor and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Eligibility, Pharmacy Claims, Institutional Services, and Dental Services Files) If the encryption algorithm for Patient ID changes, please contact MHCC before submitting.	Cannot be entirely unknown values (0s, 1s, and 9s). Must be at least 3 characters long. Must be consistent with previous quarter i.e. the same patient is identified by the same ID across payers. Must be unique for each beneficiary.	
T003	Encrypted Enrollee's IdentifierU	12	A	14	25	100%	Enrollee's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual. Leave UUID blank if it is not generated by the UUID software.	Cannot be entirely unknown values (0s, 1s, and 9s). Must be 12 characters long. Alphabetical characters must be lower-case as generated by the UUID application. Must be consistent with previous quarter i.e. the same patient is identified by the same ID across payers.	
T004	Enrollee Year and Month of Birth	8	N	26	33	100%	Date of enrollee's birth using 00 instead of day.	CCYYMM00	Year and month of birth must be valid.	
T005	Enrollee Sex	1	A	34	34	99%	Sex of the enrollee.	1 Male 2 Female	Value must be valid (see list of valid values in the Field Contents column).	
T006	Enrollee Zip Code of Residence +4 digit add-on code	10	A	35	44	99%	Zip code of enrollee's residence.	5-digit US Postal Service code plus 4-digit add-on code. If 4-digit add on code is available, please use the format "XXXXX-XXXX". If 4-digit add-on code is missing, please use the format of either "XXXXX-0000" or "XXXXX".	Value must be a valid US postal code. If any of the 4-digit add-on values are populated, they must all be populated. If the 4-digit add-on values are populated, the 6th digit must be a hyphen.	
T007	Patient Covered by Other Insurance Indicator	1	A	45	45	95%	Indicates whether patient has additional insurance coverage.	0 No 1 Yes, other coverage is primary 2 Yes, other coverage is secondary 9 Unknown	Value must be valid (see list of valid values in the Field Contents column).	
T008	Coverage Type	1	A	46	46		Patient's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not sold on MHBE) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 8 Small Business Options Program (SHOP) not sold on MHBE (definition of SHOP must follow what the Maryland Insurance Administration is using. See attachment at http://www.mdinsurance.state.md.us/sa/docs/documents/insurer/bulletins/15-27-definition-of-small-employer.pdf) A Student Health Plan B Individual Market (sold on MHBE) C Small Business Options Program (SHOP) sold on MHBE (definition of SHOP must follow what the Maryland Insurance Administration is using. See attachment at http://www.mdinsurance.state.md.us/sa/docs/documents/insurer/bulletins/15-27-definition-of-small-employer.pdf) Z Unknown	Value must be valid (see list of valid values in the Field Contents column).	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
T009	Source Company	1	A	47	47		Defines the payor company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.	2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 3 Third-Party Administrator (TPA) Unit This field is optional, but must be populated in the Eligibility file.	Value must be valid (see list of valid values in the Field Contents column).	
T010	Claim Related Condition	1	A	48	48		Describes connection, if any, between patient's condition and employment, automobile accident, or other accident.	0 Non-accident (default) 1 Work 2 Auto Accident 3 Other Accident 9 Unknown	Value must be valid (see list of valid values in the Field Contents column).	
T011	Practitioner Federal Tax ID	9	A	49	57	100%	Employer Tax ID of the practitioner, practice or office facility receiving payment for services.	TIN	Must be 9 characters long. Value must be a valid federal tax ID.	
T012	Participating Provider Status	1	A	58	58	95%	Indicates if the service was provided by a provider that participates in the payor's network.	1 Participating 2 Non-Participating 3 Unknown/Not Coded 9 No Network for this Plan	Value must be valid (see list of valid values in the Field Contents column).	
T013	Record Status	1	A	59	59	95%	Describes payment and adjustment status of a claim. Adjustments include paying a claim more than once, paying additional services that may have been denied, or crediting a provider due to overpayment or paying the wrong provider.	1 Final Bill 8 Capitated or Global Contract Services	Value must be valid (see list of valid values in the Field Contents column).	
T014	Claim Control Number	23	A	60	82	100%	Internal payor claim number used for tracking.	Include on each record as this is the key to summarizing service detail to claim level	Must be at least 2 characters long. Cannot be entirely unknown values (0s and 9s).	
T015	Claim Paid Date	8	N	83	90	100%	The date that the claim was paid. This date should agree with the paid date the Finance and Actuarial department is using in your organization. If there is a lag between the time a claim is authorized and paid, please contact MHCC for advice on which date field to use.	CCYYMMDD	Must be a valid date value.	
T016	Filler	2		91	92		Filler	Used to be Number of Line Items		
T017	Service From Date	8	N	93	100	100%	First date of service for a procedure in this line item.	CCYYMMDD	Must be a valid date value.	
T018	Service Thru Date	8	N	101	108	100%*	Last date of service for this line item.	CCYYMMDD If the Service Thru Date is not reported, then assume that the Service From Date (T017) and the Service Thru Date are the same	Must be a valid date value.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
T019	Place of Service	2	A	109	110	99%	Two-digit numeric code that describes where a service was rendered.	CMS definitions: 11 Provider's Office 12 Patient's Home 13 Assisted Living Facility 17 Walk-in Retail Health Clinic 18 Place of Employment - Worksite 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – Land 42 Ambulance – Air or Water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 57 Non-residential Substance Abuse Treatment Facility 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic	Value must be valid (see list of valid values in the Field Contents column).	
T020	Service Location Zip Code +4digit add-on code	10	A	111	120	95%	Zip code for location where service described was provided.	5-digit US Postal Service code plus 4-digit add-on code. If 4-digit add on code is available, please use the format "XXXXX-XXXX". If 4-digit add-on code is missing, please use the format of either "XXXXX-0000" or "XXXXX".	Value must be a valid US postal code. If any of the 4-digit add-on values are populated, they must all be populated. If the 4-digit add-on values are populated, the 6th digit must be a hyphen.	
T021	Procedure Code	5	A	121	125	95%	Describes the health care service provided (CDT).		Value must be a valid CDT code.	
T022	Servicing Practitioner ID	11	A	126	136	100%	Payor-specific identifier for the practitioner rendering health care service(s).		Must be populated with values that are not unknown (entirely 0s and 9s).	
T023	Billed Charge	9	N	137	145	100%	A practitioner's billed charges rounded to whole dollars.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
T024	Allowed Amount	9	N	146	154	100%	Maximum amount contractually allowed. This is generally equal to the sum of patient liability and payor reimbursement.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	Modified description for clarity.
T025	Reimbursement Amount	9	N	155	163	100%	Amount paid to Employer Tax ID # of rendering physician as listed on claim.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
T026	Date of Enrollment	8	N	164	171		The start date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 81)	CCYYMMDD Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient not enrolled at start of reporting period, but enrolled during reporting period. This field is optional, but must be populated in the Eligibility file.	Must be a valid date value.	
T027	Date of Disenrollment	8	N	172	179		The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 81)	CCYYMMDD If patient is still enrolled on the last day of the reporting period, enter 20991231. If patient disenrolled before end of reporting period enter date disenrolled. This field is optional, but must be populated in the Eligibility file.	Must be a valid date value or left blank.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
T028	Patient Deductible	9	N	180	188	100%	The fixed amount that the patient must pay for covered medical services before benefits are payable.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
T029	Patient Coinsurance or Patient Co-payment	9	N	189	197	100%	The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
T030	Other Patient Obligations	9	N	198	206	100%	Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payor reimbursement), non-covered services, or penalties.	Round decimal places to nearest whole number. For example, "193.75" would round to "194."	Must be an integer.	
T031	Servicing Practitioner Individual National Provider Identifier (NPI) Number	10	A	207	216	100%	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf	Value must be a valid NPI number.	
T032	Practitioner National Provider Identifier (NPI) Number used for Billing	10	A	217	226	100%	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner or an organization for billing purposes.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf	Value must be a valid NPI number.	
T033	Product Type	1	A	227	227		Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits). Code based on how the product is primarily marketed. Code must be consistent from year to year.	1 Exclusive Provider Organization (in any form) 2 Health Maintenance Organization 3 Indemnity 4 Point of Service (POS) 5 Preferred Provider Organization (PPO) 6 Limited Benefit Plan (Mini-Meds) 7 Student Health Plan 8 Catastrophic This field is optional, but must be populated in the Eligibility	Value must be valid (see list of valid values in the Field Contents column).	
T034	Payor ID Number	4	A	228	231	100%	Payor assigned submission identification number.		Value must match payor's assigned identification number. Value must be identical in all records.	
T035	Source System	1	A	232	232	100%	Identify the source system (platforms or business units) from which the data was obtained by using an alphabet letter (A, B, C, D, etc...) Please ensure that the source system letter used is consistent from quarter to quarter, as well as with the source system letter indicated on the MCDB Portal.	A – Z. If only submitted for one source system, default is A.	Value must be valid (see list of valid values in the Field Contents column). Must be consistent with previous quarter.	
T036	Encrypted Contract or Group Number	20	A	233	252		Payor assigned contract or group number for the plan sponsor using an encryption algorithm generated by the payor.	This number should be the same for all family members on the same plan.	Must be at least 2 characters long.	
T037	Relationship to Policyholder	1	A	253	253		Member's relationship to subscriber/insured.	1 Self-employed 2 Spouse 3 Child 4 Other Dependent 5 Other Adult 9 Unknown	Value must be valid (see list of valid values in the Field Contents column).	
T038	Tooth Number/Letter – 1	2	A	254	255		Report the tooth identifier(s) when Current Dental Terminology Code is within given range.	Up to four (4) Tooth Number/Letter fields can be entered.	Value must be populated.	
T039	Tooth – 1 Surface – 1	5	A	256	260		Report the tooth surface(s) that this service relates to. Provides further detail on procedure(s). Required when Tooth Number/Letter is populated.	Up to six (6) Tooth Surface fields can be entered for each Tooth Number/Letter entry.	Value must be populated.	
T040	Tooth – 1 Surface – 2	5	A	261	265		See comment under Tooth - 1 Surface - 1.		Value must be populated.	
T041	Tooth – 1 Surface – 3	5	A	266	270		See comment under Tooth - 1 Surface - 1.		Value must be populated.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
T042	Tooth – 1 Surface – 4	5	A	271	275		See comment under Tooth - 1 Surface - 1.		Value must be populated.	
T043	Tooth – 1 Surface – 5	5	A	276	280		See comment under Tooth - 1 Surface - 1.		Value must be populated.	
T044	Tooth – 1 Surface – 6	5	A	281	285		See comment under Tooth - 1 Surface - 1.		Value must be populated.	
T045	Tooth Number/Letter – 2	2	A	286	287		Report the tooth identifier(s) when Current Dental Terminology Code is within given range.	Up to four (4) Tooth Number/Letter fields can be entered.	Value must be populated.	
T046	Tooth – 2 Surface – 1	5	A	288	292		Report the tooth surface(s) that this service relates to. Provides further detail on procedure(s). Required when Tooth Number/Letter is populated.	Up to six (6) Tooth Surface fields can be entered for each Tooth Number/Letter entry.	Value must be populated.	
T047	Tooth – 2 Surface – 2	5	A	293	297		See comment under Tooth - 2 Surface - 1.		Value must be populated.	
T048	Tooth – 2 Surface – 3	5	A	298	302		See comment under Tooth - 2 Surface - 1.		Value must be populated.	
T049	Tooth – 2 Surface – 4	5	A	303	307		See comment under Tooth - 2 Surface - 1.		Value must be populated.	
T050	Tooth – 2 Surface – 5	5	A	308	312		See comment under Tooth - 2 Surface - 1.		Value must be populated.	
T051	Tooth – 2 Surface – 6	5	A	313	317		See comment under Tooth - 2 Surface - 1.		Value must be populated.	
T052	Tooth Number/Letter – 3	2	A	318	319		Report the tooth identifier(s) when Current Dental Terminology Code is within given range.	Up to four (4) Tooth Number/Letter fields can be entered.	Value must be populated.	
T053	Tooth – 3 Surface – 1	5	A	320	324		Report the tooth surface(s) that this service relates to. Provides further detail on procedure(s). Required when Tooth Number/Letter is populated.	Up to six (6) Tooth Surface fields can be entered for each Tooth Number/Letter entry.	Value must be populated.	
T054	Tooth – 3 Surface – 2	5	A	325	329		See comment under Tooth - 3 Surface - 1.		Value must be populated.	
T055	Tooth – 3 Surface – 3	5	A	330	334		See comment under Tooth - 3 Surface - 1.		Value must be populated.	
T056	Tooth – 3 Surface – 4	5	A	335	339		See comment under Tooth - 3 Surface - 1.		Value must be populated.	
T057	Tooth – 3 Surface – 5	5	A	340	344		See comment under Tooth - 3 Surface - 1.		Value must be populated.	
T058	Tooth – 3 Surface – 6	5	A	345	349		See comment under Tooth - 3 Surface - 1.		Value must be populated.	
T059	Tooth Number/Letter – 4	2	A	350	351		Report the tooth identifier(s) when Current Dental Terminology Code is within given range.	Up to four (4) Tooth Number/Letter fields can be entered.	Value must be populated.	
T060	Tooth – 4 Surface – 1	5	A	352	356		Report the tooth surface(s) that this service relates to. Provides further detail on procedure(s). Required when Tooth Number/Letter is populated.	Up to six (6) Tooth Surface fields can be entered for each Tooth Number/Letter entry.	Value must be populated.	
T061	Tooth – 4 Surface – 2	5	A	357	361		See comment under Tooth - 4 Surface - 1.		Value must be populated.	
T062	Tooth – 4 Surface – 3	5	A	362	366		See comment under Tooth - 4 Surface - 1.		Value must be populated.	
T063	Tooth – 4 Surface – 4	5	A	367	371		See comment under Tooth - 4 Surface - 1.		Value must be populated.	
T064	Tooth – 4 Surface – 5	5	A	372	376		See comment under Tooth - 4 Surface - 1.		Value must be populated.	
T065	Tooth – 4 Surface – 6	5	A	377	381		See comment under Tooth - 4 Surface - 1.		Value must be populated.	
T066	Dental Quadrant – 1	2	A	382	383		Report the standard quadrant identifier when CDT indicates procedures of 3 or more consecutive teeth. Provides further detail on procedure(s).	Up to four (4) Dental Quadrant fields can be entered.	Value must be populated.	
T067	Dental Quadrant – 2	2	A	384	385		See comment under Dental Quadrant - 1.		Value must be populated.	
T068	Dental Quadrant – 3	2	A	386	387		See comment under Dental Quadrant - 1.		Value must be populated.	
T069	Dental Quadrant – 4	2	A	388	389		See comment under Dental Quadrant - 1.		Value must be populated.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
T070	Orthodontics Treatment	1	A	390	390		Indicate if the treatment is for Orthodontics.	0 No 1 Yes	Value must be 1 or 0.	
T071	Date Appliance Placed	8	N	391	398		If treatment is for Orthodontics, then provide the date the appliance was placed.	CCYYMMDD	Must be a valid date value.	
T072	Months of Treatment Remaining	2	N	399	400		If treatment is for Orthodontics, then provide the number of months of treatment remaining.	Number of months remaining for treatment.	Must contain a numeric value.	
T073	Prosthesis Replacement	1	A	401	401		Indicate if the treatment is for the replacement of Prosthesis.	0 No 1 Yes	Value must be 1 or 0.	
T074	Date of Prior Placement	8	N	402	409		If treatment is for replacement of Prosthesis, then provide the prior date of Prosthesis placement.	CCYYMMDD	Must be a valid date value.	
T075	Reporting Quarter	1	A	410	410	100%	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31	Value must match the current reporting quarter.	
T076	Claim Adjudication Date	8	N	411	418	100%	The date that the claim was adjudicated.	CCYYMMDD	Must be a valid date value.	
T077	Claim Line Number	4	A	419	422	100%	Line number for the service within a claim.	The first line is 1 and subsequent lines are incremented by 1	Must be an integer.	
T078	Version Number	4	A	423	426	100%	Version number of this claim service line. The version number begins with 1 and is incremented by 1 for each subsequent version of that service line.		Must be an integer.	
T079	Claim Line Type	1	A	427	427	100%	Code Indicating Type of Record. Example: Original, Void, Replacement, Back Out, Amendment	0 Original V Void R Replacement B Back Out A Amendment	Value must be valid (see list of valid values in the Field Contents column).	
T080	Former Claim Number	23	A	428	450	30%	Former claims control number or claims control number used in the original claim that corresponds to this claim line.	Must be different to the claims control number reported under field # 14	Must be at least 2 characters long. Must be populated with values that are not unknown (entirely 0s and 9s).	

ELIGIBILITY DATA REPORT SUBMISSION

This report details information on the characteristics of all enrollees covered for medical services under the plan for the quarterly reporting period designated – First Quarter: Claims paid from January 1, 2017 through March 31, 2017; Second Quarter: Claims paid from April 1, 2017 through June 30, 2017; Third Quarter: Claims paid from July 1, 2017 through September 30, 2017; and Fourth Quarter: Claims paid from October 1, 2017 through December 31, 2017. Please provide an entry for each month that the enrollee was covered by a general health benefit plan regardless of whether or not the enrollee received any covered services during the reporting year.

(For example, an enrollee with 3 months of coverage will have 3 eligibility records; an enrollee with 2 months of coverage will only have 2 records.)

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
E001	Record Identifier	1	A	1	1	100%	The value is 5	5 Eligibility	In the Eligibility file, this field must be 5.	
E002	Encrypted Enrollee's IdentifierP	12	A	2	13	100%	Enrollee's unique identification number assigned by payor and encrypted.	The unique ID for each person on this file should correspond to the same unique Enrollee ID used for all other files (Eligibility, Pharmacy Claims, Institutional Services, and Dental Services Files) If the encryption algorithm for Enrollee ID changes, please contact MHCC before submitting.	Cannot be entirely unknown values (0s, 1s, and 9s). Must be at least 3 characters long. Must be consistent with previous quarter i.e. the same patient is identified by the same ID across payers. Must be unique for each beneficiary.	
E003	Encrypted Enrollee's IdentifierU	12	A	14	25	100%	Enrollee's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual. The Commission expects the algorithm to be applied to every eligibility record. Leave UUID blank if it is not generated by the UUID software.	Cannot be entirely unknown values (0s, 1s, and 9s). Must be 12 characters long. Alphabetical characters must be lower-case as generated by the UUID application. Must be consistent with previous quarter i.e. the same patient is identified by the same ID across payers.	
E004	Enrollee Year and Month of Birth	8	N	26	33	100%	Date of enrollee's birth using 00 instead of day.	CCYYMM00	Year and month of birth must be valid.	
E005	Enrollee Sex	1	A	34	34	99%	Sex of the enrollee.	1 Male 2 Female	Value must be valid (see list of valid values in the Field Contents column).	
E006	Enrollee Zip Code of Residence +4 digit add-on code	10	A	35	44	99%	Zip code of enrollee's residence.	5-digit US Postal Service code plus 4-digit add-on code. If 4-digit add on code is available, please use the format "XXXXX-XXXX". If 4-digit add-on code is missing, please use the format of either "XXXXX-0000" or "XXXXX".	Value must be a valid US postal code. If any of the 4-digit add-on values are populated, they must all be populated. If the 4-digit add-on values are populated, the 6th digit must be a hyphen.	
E007	Enrollee County of Residence	3	A	45	47		County of enrollee's residence. If known, please provide. If not known, MHCC will arbitrarily assign using Zip code of residence.	001 Allegany 003 Anne Arundel 005 Baltimore County 009 Calvert 011 Caroline 013 Carroll 015 Cecil 017 Charles 019 Dorchester 021 Frederick 023 Garrett 025 Harford 027 Howard 029 Kent 031 Montgomery 033 Prince George's 035 Queen Anne's 037 St. Mary's 039 Somerset 041 Talbot 043 Washington 045 Wicomico 047 Worcester 510 Baltimore City 999 Unknown	Value must be valid (see list of valid values in the Field Contents column).	
E008	Source of Direct Reporting of Enrollee Race	1	A	48	48	95%	Indicate the source of direct reporting of enrollee race.	1 Enrollee reported to payor 2 Enrollee reported to another source 9 Missing/Unknown/Not specified	Value must be valid (see list of valid values in the Field Contents column).	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
E009	Race Category White – Direct	1	A	49	49		Enter whether the self-defined race of the enrollee is White or Caucasian. White is defined as a person having lineage in any of the original peoples of Europe, the Middle East, or North Africa.	0 No 1 Yes	Value must be 1 or 0.	
E010	Race Category Black or African American – Direct	1	A	50	50		Enter whether the self-defined race of the enrollee is Black or African American. Black or African American is defined as a person having lineage in any of the Black racial groups of Africa.	0 No 1 Yes	Value must be 1 or 0.	
E011	Race Category American Indian or Alaska Native – Direct	1	A	51	51		Enter whether the self-defined race of the enrollee is American Indian or Alaska Native. American Indian or Alaska Native is defined as a person having lineage in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.	0 No 1 Yes	Value must be 1 or 0.	
E012	Race Category Asian – Direct	1	A	52	52		Enter whether the self-defined race of the enrollee is Asian. Asian is defined as a person having lineage in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	0 No 1 Yes	Value must be 1 or 0.	
E013	Race Category Native Hawaiian or Pacific Islander – Direct	1	A	53	53		Enter whether the self-defined race of the enrollee is Native Hawaiian or Other Pacific Islander. Native Hawaiian or Other Pacific Islander is defined as a person having lineage in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	0 No 1 Yes	Value must be 1 or 0.	
E014	Race Category Other – Direct	1	A	54	54		Enter whether the self-defined race of the enrollee is Other.	0 No 1 Yes	Value must be 1 or 0.	
E015	Race Category Declined to Answer – Direct	1	A	55	55		Enter whether the enrollee declined to disclose their race.	0 No 1 Yes	Value must be 1 or 0.	
E016	Race Category Unknown or Cannot be Determined – Direct	1	A	56	56		Enter whether the race of the enrollee is unknown or cannot be determined.	0 No 1 Yes	Value must be 1 or 0.	
E017	Imputed Race with Highest Probability	1	A	57	57	95%	Race of enrollee.	1 American Indian or Alaska Native 2 Asian 3 Black or African American 4 Native Hawaiian or Other Pacific Islander 5 White/Caucasian 6 Some Other Race 9 Missing/Unknown/Not specified	Value must be valid (see list of valid values in the Field Contents column).	
E018	Probability of Imputed Race Assignment	3	A	58	60	95%	Specify the probability of race assignment; probability used in race determination.	Percentage	Must be an integer.	
E019	Source of Direct Reporting of Enrollee Ethnicity	1	A	61	61	95%	Indicate source of reporting enrollee ethnicity.	1 Enrollee reported to payor 2 Enrollee reported to another source 9 Missing/Unknown/Not specified	Value must be valid (see list of valid values in the Field Contents column).	
E020	Enrollee OMB Hispanic Ethnicity	1	A	62	62		Ethnicity of enrollee.	1 Hispanic or Latino or Spanish origin 2 Not Hispanic or Latino or Not of Spanish origin 9 Missing/Unknown/Not specified	Value must be valid (see list of valid values in the Field Contents column).	
E021	Imputed Ethnicity with Highest Probability	1	A	63	63	95%	Enter the Ethnicity of the enrollee.	1 Hispanic or Latino or Spanish origin 2 Not Hispanic or Latino or Not of Spanish origin 7 Declined to Answer 9 Missing/Unknown/Not specified	Value must be valid (see list of valid values in the Field Contents column).	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
E022	Probability of Imputed Ethnicity Assignment	3	A	64	66	95%	Specify the probability of ethnicity assignment; probability used in ethnicity determination.	Percentage	Must be an integer.	
E023	Enrollee Preferred Spoken Language for a Healthcare Encounter	2	A	67	68		A locally relevant list of languages has been developed by the Commission.	01 English 02 Albanian 03 Amharic 04 Arabic 05 Burmese 06 Cantonese 07 Chinese (simplified & traditional) 08 Creole (Haitian) 09 Farsi 10 French (European) 11 Greek 12 Gujarati 13 Hindi 14 Italian 15 Korean 16 Mandarin 17 Portuguese (Brazilian) 18 Russian 19 Serbian 20 Somali 21 Spanish (Latin America) 22 Tagalog (Pilipino) 23 Urdu 24 Vietnamese	Value must be valid (see list of valid values in the Field Contents column).	
E024	Coverage Type	1	A	69	69	99%	Enrollee's type of insurance coverage. For payors that participate in the sale of ACA compliant health insurance products on or off the Maryland Health Benefit Exchange (MHBE), membership and allowed claims data in the MCDB must be consistent with the membership and allowed claims data submitted by your company's Actuarial Pricing/Rating department to the Maryland Insurance Administration (MIA) via Actuarial Memorandums and rate filings. The Individual and Small Group markets (Non-Grandfathered Health Plans only) are affected by this MCDB v. MIA data reconciliation and will result in MCDB data resubmissions if discrepancies in the excess 2.5% exists.	1 Medicare Supplemental (i.e., Individual, Group, WPA) 2 Medicare Advantage Plan 3 Individual Market (not sold on MHBE) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 8 Small Business Options Program (SHOP) not sold on MHBE (definition of SHOP must follow what the Maryland Insurance Administration is using. See attachment at http://www.mdinsurance.state.md.us/sa/docs/documents/insurer/bulletins/15-27-definition-of-small-employer.pdf) A Student Health Plan B Individual Market (sold on MHBE) C Small Business Options Program (SHOP) sold on MHBE (definition of SHOP must follow what the Maryland Insurance Administration is using. See attachment at http://www.mdinsurance.state.md.us/sa/docs/documents/insurer/bulletins/15-27-definition-of-small-employer.pdf)	Value must be valid (see list of valid values in the Field Contents column).	Modified description for clarity.
E025	Source Company	1	A	70	70	99%	Defines the payor company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.	1 Health Maintenance Organization 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 3 Third-Party Administrator (TPA) Unit	Value must be valid (see list of valid values in the Field Contents column).	
E026	Product Type	1	A	71	71	95%	Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits).	1 Exclusive Provider Organization (in any form) 2 Health Maintenance Organization 3 Indemnity 4 Point of Service (POS) 5 Preferred Provider Organization (PPO) 6 Limited Benefit Plan (Mini-Meds) 7 Student Health Plan 8 Catastrophic	Value must be valid (see list of valid values in the Field Contents column).	
E027	Policy Type	1	A	72	72	95%	Type of policy.	1 Individual 2 Any combination of two or more persons	Value must be valid (see list of valid values in the Field Contents column).	
E028	Encrypted Contract or Group Number	20	A	73	92	95%	Payor assigned contract or group number for the plan sponsor using an <u>encryption algorithm generated by the payor.</u>	This number should be the same for all family members on the same plan (request a waiver in the case of individual plans).	Value must be populated.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
E029	Employer Federal Tax ID Number	9	A	93	101	100%	Employer Federal Tax ID number will be encrypted by the database contractor in such a way that an employer will have the same encrypted ID across all payor records and the same employer has the same encrypted number from year to year.	Threshold does not apply to individual market plans (request a waiver in the case of individual plans).	Must be 9 characters long. Value must be a valid federal tax ID.	
E030	Medical Coverage Indicator	1	A	102	102	95%	Medical Coverage	0 No 1 Yes	Value must be 1 or 0.	
E031	Pharmacy Coverage Indicator	1	A	103	103	95%	Prescription Drug Coverage	0 No 1 Yes	Value must be 1 or 0.	
E032	Behavioral Health Services Coverage Indicator	1	A	104	104	95%	Behavioral Health Services Coverage	0 No 1 Yes	Value must be 1 or 0.	
E033	Dental Coverage Indicator	1	A	105	105	95%	Dental Coverage	0 No 1 Yes	Value must be 1 or 0.	
E034	Plan Liability	1	A	106	106	100%	Indicates if insurer is at risk for the patient's service use or the insurer is simply paying claims as an ASO.	1 Risk (under Maryland contract) 2 Risk (under non-Maryland contract) 3 ASO (employer self-insured, under Maryland contract) 4 ASO (employer self-insured, under non-Maryland Contract)	Value must be valid (see list of valid values in the Field Contents column).	
E035	Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	1	A	107	107	100%	Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) or Health Resources Account (HRA).	0 No 1 Yes	Value must be 1 or 0.	
E036	Start Date of Coverage	8	N	108	115	100%	The start date for benefits in the month (for example, if the enrollee was insured at the start of the month of January in 2016, the start date is 20160101)	CCYYMMDD Provide an entry for each month that the enrollee was covered regardless of whether or not the enrollee received any covered services during the reporting year. For example, a patient that is covered for three months would have three entries. A patient with no previous coverage should be listed as the date coverage began, otherwise use the 1st of the month as the begin date for each month of continued coverage.	Must be a valid date value. Date must be in the same month as End Date of Coverage.	
E037	End Date of Coverage	8	N	116	123	100%	The end date for benefits in the month (for example, if the enrollee was insured for the entire month of January in 2016, the end date is 20160131)	CCYYMMDD Provide an entry for each month that the enrollee was covered regardless of whether or not the enrollee received any covered services during the reporting year. For example, a patient that is covered for three months would have three entries. A patient with terminated coverage should use the date that coverage ended, otherwise use the last day of the month as the end date for each month of continued coverage.	Must be a valid date value. Date must be in the same month as Start Date of Coverage.	
E038	Date of FIRST Enrollment	8	N	124	131		Unlike the Date of Enrollment listed on the other files, which refers to the start date of enrollment in this data submission period, this Date of FIRST Enrollment should reflect the date that the patient was initially enrolled in the plan.	CCYYMMDD Must be consistent for the same enrollee within the same plan across all records.	Must be a valid date value.	Removed threshold.
E039	Date of Disenrollment	8	N	132	139		The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 72)	CCYYMMDD If patient is still enrolled on the last day of the reporting period, enter 20991231. If patient disenrolled before end of reporting period enter date disenrolled. Must be consistent for the same enrollee within the same plan across all records.	Must be a valid date value or left blank.	Removed threshold.
E040	Coverage Period End Date	8	N	140	147	100%	Contract renewal date, after which benefits, such as deductibles and out of pocket maximums reset.	CCYYMMDD Do not use the last renewal date, use the next renewal date instead.	Must be a valid date value.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
E041	Relationship to Policyholder	1	A	148	148	100%	Member's relationship to subscriber/insured.	1 Self/employee 2 Spouse 3 Child 4 Other Dependent 5 Other Adult 9 Unknown	Value must be valid (see list of valid values in the Field Contents column).	
E042	Payor ID Number	4	A	149	152	100%	Payor assigned submission identification number.		Value must match payor's assigned identification number. Value must be identical in all records.	
E043	Source System	1	A	153	153	100%	Identify the source system (platforms or business units) from which the data was obtained by using an alphabet letter (A, B, C, D, etc...) Please ensure that the source system letter used is consistent from quarter to quarter, as well as with the source system letter indicated on the MCDB Portal.	A – Z. If only submitted for one source system, default is A.	Value must be valid (see list of valid values in the Field Contents column). Must be consistent with previous quarter.	
E044	Grandfathered Plan Indicator	1	A	154	154	100%	Indicate if the plan qualifies as a "Grandfathered or Transitional Plan" under the Affordable Care Act (ACA). Please see "Grandfathered plans" definition in HHS rules 45-CFR-147.140 at: https://www.federalregister.gov/select-citation/2013/06/03/45-CFR-147.140	when the coverage type is 3 or 8, ACA compliant health plans must have the value '2', while ACA noncompliant health plans must have the value '1'. No other coverage types should have the value '1' for this field. 1 Grandfathered 2 Non-Grandfathered 3 Transitional 4 Not Applicable Note: Only applies to Individual and Small Group products.	Value must be valid (see list of valid values in the Field Contents column).	Modified field contents.
E045	Plan or Product ID Number	20	A	155	174	100%	Payor ID number associated with an enrollee's coverage and benefits in the claim adjudication system.		Value must be populated.	
E046	Subscriber ID Number	20	A	175	194	100%	Subscriber ID number associated with individual or family enrollment.	Encrypt the same as PatientIDP, consistently with PatientIDP: The unique ID for each person on this file would correspond to the same unique Subscriber ID used for all other files (Professional Services, Pharmacy Claims, and Institutional Services Files).	Value must be populated.	
E047	Health Insurance Oversight System (HIOS) Number	20	A	195	214	100%	HIOS ID number supplied by the federal government.	Only required for Non-Grandfathered Individual and Small Group Health Plans or Qualified Health Plans (QHPs)	Value must be populated.	
E048	Master Patient Index	40	A	215	254	100%	Indicates the unique patient identifier assigned by Maryland's Health Information Exchange, Chesapeake Regional Information System for our Patients (CRISP)	MPI Leave this field blank. However, MHCC expects payors to provide patient characteristics needed by CRISP to generate the MPI (no waiver required)	Value must be left blank.	
E049	Reporting Quarter	1	A	255	255	100%	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31	Value must match the current reporting quarter.	
E050	Metal Level Plan Indicator	1	A	256	256	100%	Indicate plan type under the Affordable Care Act (ACA)	Note: Only applies to Non-GrandFathered Health Plans or Qualified Health Plans (QHPs) under ACA (coverage types 3, 8, B and C). If coverage type is not one of these values, this field must be left blank. 1 Bronze 2 Silver 3 Gold 4 Platinum 0 Catastrophic (not considered a metal level)	Metal levels are based on the actuarial value (AV) or metal AV (relative generosity of health plans with different cost-sharing attributes or how much each plan pays on average) of the plan. For example Bronze plan has a metal AV of 60%, Silver 70%, Gold 80% and Platinum 90%. Catastrophic AV is always lower than Bronze. Enrollment for these metal levels should be consistent with what the Actuarial department in your organization is reporting to the Maryland Insurance Administration (MIA)	Modified field contents.

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
E051	Cost-Sharing Reduction Indicator	1	A	257	257	100%	(CSR_Indicator) Indicate cost-sharing reduction under the Affordable Care Act (ACA)	Note: Only applies to Non-GrandFathered Health Plans or Qualified Health Plans (QHPs) under ACA (coverage types 3, 8, B and C). If coverage type is not one of these values, this field must be left blank. 1 Enrollees in 94% Actuarial Value (AV) Silver Plan Variation 2 Enrollees in 87% AV Silver Plan Variation 3 Enrollees in 73% AV Silver Plan Variation 4 Enrollees in Zero Cost Sharing Plan Variation of Platinum Level QHP 5 Enrollee in Zero Cost Sharing Plan Variation of Gold Level QHP 6 Enrollee in Zero Cost Sharing Plan Variation of Silver Level QHP 7 Enrollee in Zero Cost Sharing Plan Variation of Bronze Level QHP 8 Enrollee in Limited Cost Sharing Plan Variation 0 Non-CSR recipient, and enrollees with unknown CSR	The cost-sharing indicator is a Person-level indicator. Enrollees who qualify for cost-sharing reductions are assigned cost-sharing indicator values = 1-8. Non-Cost-Sharing recipients are assigned a cost-sharing indicator value = 0. Information for this field is required by the Maryland Insurance Administration (MIA) and should be consistent with what the Actuarial department in your organization is reporting to the MIA. For more information on the Cost-Sharing Indicator (CSR_INDICATOR) see attachment at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/DIY-instructions-5-20-14.pdf (pages 8-9).	Modified field contents.

PROVIDER DIRECTORY REPORT SUBMISSION

This report details all health care Practitioners (including other health care professionals, dental/vision services covered under a general health benefit plan, and office facilities) and Suppliers that provided services to your enrollees for the reporting period designated – First Quarter: Claims paid from January 1, 2017 through March 31, 2017; Second Quarter: Claims paid from April 1, 2017 through June 30, 2017; Third Quarter: Claims paid from July 1, 2017 through September 30, 2017; Fourth Quarter: Claims paid from October 1, 2017 through December 31, 2017. Please provide information for all in-State Maryland practitioners/suppliers and all out-of-State practitioners/suppliers serving applicable insureds.

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
D001	Record Identifier	1	A	1	1	100%	The value is 3	3 Provider Services	In the Provider file, this field must be 3.	
D002	Practitioner/Supplier ID	11	A	2	12	100%	Payor-specific identifier for a practitioner, practice, or office facility rendering health care service(s).	Payor encrypted. Field must match Servicing Practitioner ID # in the Professional Services and Dental Services file, and Prescriber Practitioner ID in the Pharmacy file.	Must be populated with values that are not unknown (entirely 0s and 9s).	
D003	Practitioner/Supplier Federal Tax ID	9	A	13	21	100%	Employer Tax ID # of the practitioner, practice or office facility receiving payment for services.	Remove embedded dashes. Same as Federal Tax ID # in Professional Services and Dental Services File.	Must be 9 characters long. Value must be a valid federal tax ID.	
D004	Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization	31	A	22	52	100%	Last name of practitioner or complete name of multi-practitioner health care organization.	Please truncate if name of practitioner or medical organization exceeds 31 characters. Use specific (separate) fields for Practitioner First Name and Last Name	Must be at least 5 characters long. Cannot contain more than 3 special characters.	
D005	Practitioner/Supplier First Name	19	A	53	71	100%	Practitioner's first name.	Individual provider's first name. Leave blank if organization (threshold does not apply).	Must be at least 5 characters long. Cannot contain more than 3 special characters.	
D006	Practitioner Middle Initial	1	A	72	72			First letter of individual provider's middle name.	Must be 3 or less characters long.	
D007	Practitioner Name Suffix	4	A	73	76			Individual provider's name suffix, such as Jr., Sr., II, III, IV, or V.	Must be populated.	
D008	Practitioner Credential	5	A	77	81			Abbreviations for professional degrees or credentials used or held by an individual provider, such as MD, DDS, CSW, CNA, AA, NP, PSY.	Must be populated.	
D009	Practitioner/Supplier Specialty – 1*	10	A	82	91	100%*	The health care field in which a practitioner is licensed, certified, or otherwise authorized under Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program. Up to 3 codes may be listed.	Please reference the National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy, Version 13.0, January 2013 Code Book available on the MHCC website at: http://mhcc.dhmfh.maryland.gov/payercompliance/Documents/Taxonomy_13_0.pdf If the Practitioner Individual NPI (D014) or the Practitioner Organizational NPI numbers (D015) are not provided, then the Practitioner Specialty code must be filled using the NUCC Health Care Provider Taxonomy codes. If a payor requests to provide internal practitioner specialty coding, then a crosswalk of the internal practitioner specialty codes to the appropriate taxonomy specialty codes must be provided.	Value must be a valid practitioner/supplier specialty code.	
D010	Practitioner/Supplier Specialty – 2*	10	A	92	101				Value must be a valid practitioner/supplier specialty code.	
D011	Practitioner/Supplier Specialty – 3*	10	A	102	111				Value must be a valid practitioner/supplier specialty code.	

Field ID	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold	Description	Field Contents	Validation Rule	Changes
D012	Practitioner DEA #	11	A	112	122	100%	Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act.	Must match DEA# in Pharmacy File.	The first two characters must be letters. Value must be valid according to the check equation.	
D013	Indicator for Multi-Practitioner Health Care Organization	1	A	123	123	99%		0 Solo Practitioner 1 Multiple Practitioners	Value must be valid (see list of valid values in the Field Contents column).	
D014	Practitioner Individual National Provider Identifier (NPI) Number	10	A	124	133	100%	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf	Value must be a valid NPI number.	
D015	Practitioner Organizational National Provider Identifier (NPI) Number	10	A	134	143	100%	Federal identifier assigned by the federal government for use in all HIPAA transactions to an organization for billing purposes. Must be populated if practitioner is a Multi-Practitioner Health Care Organization.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf	Value must be a valid NPI number.	
D016	Payor ID Number	4	A	144	147	100%	Payor assigned submission identification number.		Value must be valid (see list of valid values in the Field Contents column).	
D017	Source System	1	A	148	148	100%	Identify the source system (platforms or business units) <i>from which the data was obtained</i> by using an alphabet letter (A, B, C, D, etc...) Please ensure that the source system letter used is consistent from quarter to quarter, as well as with the source system letter indicated on the MCDB Portal.	A – Z. If only submitted for one source system, default is A.	Value must be valid (see list of valid values in the Field Contents column). Must be consistent with previous quarter.	
D018	Reporting Quarter	1	A	149	149	100%	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31	Value must match the current reporting quarter.	

CRISP DEMOGRAPHICS REPORT SUBMISSION

Each PNUM-Source System combination must have a distinct demographics file, corresponding to the MCDB Eligibility Data Report for the same time period. Demographics files must be pipe-delimited text files. Each submission will be a full replacement file and include all members who were enrolled in the date range specified by MHCC (e.g. 1/1/2017 – 3/31/2017 for 2017Q1). All submissions for 2017 files must be made on the MCDB Portal.

Please note that the formats of dates and of gender in this file are different than for the claims and eligibility files.

Field ID	Field Name	Max Length	Type A=alphanumeric N=numeric	Threshold	Description	Field Contents	Validation Rule	Changes
C001	PNUM	4	A	100%	Payor number assigned by MHCC.	Payor's assigned submission identification number.	Value must match payor's assigned identification number. Value must be identical in all records.	
C002	Member ID	60	A	100%	This is the patient identifier from the carrier's internal patient EHR system. This is <u>not</u> the UUID generated using MHCC's number generator software. **Notify MHCC/CRISP if Member ID / EHR system changes for the current submission, compared to the previous submission(s).		Must be populated.	
C003	Encrypted Enrollee's IdentifierP (payor-encrypted)	12	A	100%	This field must be identical to the "Encrypted Enrollee's IdentifierP" field submitted in the MCDB Eligibility Data Report to MHCC.	This field could be the same as Member ID if Member ID does not contain identifiable information e.g. SSN; otherwise, it should be a number generated by the carrier to de-identify their member ID. This is also not the UUID.	Must be populated.	
C004	Last Name	75	A	100%	Last name of the enrollee		Must be populated.	
C005	First Name	75	A	100%	First name of the enrollee		Must be populated.	
C006	Middle Name	50	A		Middle name of the enrollee			
C007	Suffix	10	A		Individual provider's name suffix, such as Jr., Sr., II, III, IV, or V.			
C008	Group ID	128	A	100%			Must be populated.	
C009	Plan ID	128	A	100%	Plan name or unique plan identifier		Must be populated.	
C010	Date Coverage Initiated	10	N	100%	Member's initial date of enrollment.	<i>Format: YYYY-MM-DD</i>	Must be a valid date value. The date that the member initially enrolled for coverage. It indicates the first day of continuous coverage.	
C011	Date Coverage Ended	10	N		Indicates the date the member's coverage was discontinued.	<i>Format: YYYY-MM-DD</i>	Must be a valid date value. Should only be populated if a member has discontinued coverage. If coverage is continuing (i.e., through the end of the date range), this field should be left blank.	
C012	Gender	1	A	100%	Gender of the enrollee	<i>Format: Only values of M, F, or U are acceptable.</i>	Value must be valid (see list of valid values in the Field Contents column).	
C013	Date of Birth	10	N	100%	This must be the DOB of the person him/herself and NOT the DOB of the primary insured person of the family.	<i>Format: YYYY-MM-DD</i>	Value must be a valid birth date. Must be populated when possible.	
C014	SSN	11	A	90%	This must be the SSN of the person him/herself and NOT the SSN of the primary insured person of the family.	<i>Format: ###-##-#### or #####</i>	Value must be a valid social security number. Must be populated when possible.	
C015	Home Address Line 1	75	A	90%			Must be populated.	
C016	Home Address Line 2	75	A					
C017	Home Address City	50	A	90%			Must be populated and be a valid city, with a valid state or territory.	
C018	Home Address State	15	A	90%			Must be populated and be a valid state or territory name or abbreviation.	
C019	Home Address County	50	A					
C020	Home Address ZIP Code	10	A	90%	Zip code of enrollee's home address.	<i>Format: ##### or #####-#### or #####</i>	Value must be a valid US postal code. If any of the 4-digit add-on values are populated, they must all be populated.	

CRISP DEMOGRAPHICS REPORT SUBMISSION

Each PNUM-Source System combination must have a distinct demographics file, corresponding to the MCDB Eligibility Data Report for the same time period. Demographics files must be pipe-delimited text files. Each submission will be a full replacement file and include all members who were enrolled in the date range specified by MHCC (e.g. 1/1/2017 – 3/31/2017 for 2017Q1). All submissions for 2017 files must be made on the MCDB Portal.

Please note that the formats of dates and of gender in this file are different than for the claims and eligibility files.

C021	Home Address Country (if foreign)	50	A		Required if foreign		Must be populated if foreign.
C022	Work Address Line 1	75	A				
C023	Work Address Line 2	75	A				
C024	Work Address City	50	A				
C025	Work Address State	15	A				
C026	Work Address County	50	A				
C027	Work Address ZIP Code	10	A		Zip code of enrollee's work address.	Format: ##### or #####-#### or #####	Value must be a valid US postal code. If any of the 4-digit add-on values are populated, they must all be populated.
C028	Work Address Country (if foreign)	50	A		Required if foreign		Must be populated if foreign.
C029	Primary Telephone #	20	A	90%	For US numbers, this should be a 10-digit phone number. For foreign numbers, this should include the country code.	Format: ###-###-####	Value must be a valid telephone number. Must be populated when possible.
C030	Secondary Telephone #	20	A		For US numbers, this should be a 10-digit phone number. For foreign numbers, this should include the country code.	Format: ###-###-####	Value must be a valid telephone number.
C031	Source System	1	A	100%	Source System code must correspond to MCDB eligibility file Source System code covering the same time period. If only reporting for one source system, use the default value of "A"	Format: single uppercase alphabetic character A – Z	Value must be valid (see list of valid values in the Field Contents column). Must be consistent with previous quarter.
C032	Reporting Calendar Year and Quarter	6	A	100%	Example: for January 1, 2017 thru March 31, 2017, use 2017Q1	Format: YYYYQ#	Value must match the current reporting quarter and year
C033	Record Identifier	1	A	100%	This value identifies the submitted file type. For Demographics File, report the value 7 for every record.	7 CRISP Demographics	In the CRISP Demographics file, this field must be 7.

MCDB Field Index (In Alphabetical Order)

Field Name	Length	Type	Field ID						
			Professional	Pharmacy	Institutional	Dental	Eligibility	Provider	CRISP
Enrollee Characteristics									
Date of Birth	10	N	-	-	-	-	-	-	C013
Encrypted Enrollee's IdentifierP	12	A	P002	R002	I002	T002	E002	-	C003
Encrypted Enrollee's IdentifierU	12	A	P003	R003	I003	T003	E003	-	-
Enrollee County of Residence	3	A	-	-	-	-	E007	-	-
Enrollee OMB Hispanic Ethnicity	1	A	-	-	-	-	E020	-	-
Enrollee Preferred Spoken Language for a Healthcare Encounter	2	A	-	-	-	-	E023	-	-
Enrollee Sex (Gender)	1	A	P005	R004	I005	T005	E005	-	C012
Enrollee Year and Month of Birth	8	N	P004	R006	I004	T004	E004	-	-
Enrollee Zip Code of Residence +4digit add-on code	10	A	P007	R005	I006	T006	E006	-	-
First Name	75	A	-	-	-	-	-	-	C005
Home Address City	50	A	-	-	-	-	-	-	C017
Home Address County	50	A	-	-	-	-	-	-	C019
Home Address Country (if foreign)	50	A	-	-	-	-	-	-	C021
Home Address Line 1	75	A	-	-	-	-	-	-	C015
Home Address Line 2	75	A	-	-	-	-	-	-	C016
Home Address State	15	A	-	-	-	-	-	-	C018
Home Address ZIP Code	10	A	-	-	-	-	-	-	C020
Imputed Ethnicity with Highest Probability	1	A	-	-	-	-	E021	-	-
Imputed Race with Highest Probability	1	A	-	-	-	-	E017	-	-
Last Name	75	A	-	-	-	-	-	-	C004
Master Patient Index	40	A	-	-	-	-	E048	-	-
Member ID	60	A	-	-	-	-	-	-	C002
Middle Name	50	A	-	-	-	-	-	-	C006
Patient Covered by Other Insurance Indicator	1	A	P008	R040	I141	T007	-	-	-
Primary Telephone #	20	A	-	-	-	-	-	-	C029
Probability of Imputed Ethnicity Assignment	3	A	-	-	-	-	E022	-	-
Probability of Imputed Race Assignment	3	A	-	-	-	-	E018	-	-
Race Category American Indian or Alaska Native – Direct	1	A	-	-	-	-	E011	-	-
Race Category Asian – Direct	1	A	-	-	-	-	E012	-	-
Race Category Black or African American – Direct	1	A	-	-	-	-	E010	-	-
Race Category Declined to Answer – Direct	1	A	-	-	-	-	E015	-	-
Race Category Native Hawaiian or Pacific Islander – Direct	1	A	-	-	-	-	E013	-	-
Race Category Other – Direct	1	A	-	-	-	-	E014	-	-
Race Category Unknown or Cannot be Determined – Direct	1	A	-	-	-	-	E016	-	-

MCDB Field Index (In Alphabetical Order)

Field Name	Length	Type	Field ID						
			Professional	Pharmacy	Institutional	Dental	Eligibility	Provider	CRISP
Race Category White – Direct	1	A	-	-	-	-	E009	-	-
Relationship to Policyholder	1	A	-	-	-	T037	E041	-	-
Secondary Telephone #	20	A	-	-	-	-	-	-	C030
Source of Direct Reporting of Enrollee Ethnicity	1	A	-	-	-	-	E019	-	-
Source of Direct Reporting of Enrollee Race	1	A	-	-	-	-	E008	-	-
SSN	11	A	-	-	-	-	-	-	C014
Suffix	10	A	-	-	-	-	-	-	C007
Work Address City	50	A	-	-	-	-	-	-	C024
Work Address County	50	A	-	-	-	-	-	-	C026
Work Address Country (if foreign)	50	A	-	-	-	-	-	-	C028
Work Address Line 1	75	A	-	-	-	-	-	-	C022
Work Address Line 2	75	A	-	-	-	-	-	-	C023
Work Address State	15	A	-	-	-	-	-	-	C025
Work Address ZIP Code	10	A	-	-	-	-	-	-	C027
Subscriber ID Number	20	A	-	-	-	-	E046	-	-
Payor Characteristics									
Payor ID Number (PNUM)	4	A	P051	R028	I142	T034	E042	D016	C001
Record Identifier	1	A	P001	R001	I001	T001	E001	D001	C033
Reporting Calendar Year and Quarter	6	A	-	-	-	-	-	-	C032
Reporting Quarter	1	A	P060	R030	I167	T075	E049	D018	-
Source Company	1	A	P010	-	-	T009	E025	-	-
Source of Processing	1	A	-	R027	-	-	-	-	-
Source System	1	A	P052	R029	I143	T035	E043	D017	C031
Plan Characteristics									
Behavioral Health Services Coverage Indicator	1	A	-	-	-	-	E032	-	-
Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	1	A	P006	-	-	-	E035	-	-
Cost-Sharing Reduction Indicator	1	A	-	-	-	-	E051	-	-
Coverage Period End Date	8	N	-	-	-	-	E040	-	-
Coverage Type	1	A	P009	-	-	T008	E024	-	-
Date Coverage Ended	10	N	-	-	-	-	-	-	C011
Date Coverage Initiated	10	N	-	-	-	-	-	-	C010
Date of Disenrollment	8	N	P043	R026	I008	T027	E039	-	-
Date of Enrollment	8	N	P042	R025	I007	T026	-	-	-
Date of FIRST Enrollment	8	N	-	-	-	-	E038	-	-
Dental Coverage Indicator	1	A	-	-	-	-	E033	-	-

MCDB Field Index (In Alphabetical Order)

Field Name	Length	Type	Field ID						
			Professional	Pharmacy	Institutional	Dental	Eligibility	Provider	CRISP
Employer Federal Tax ID Number	9	A	-	-	-	-	E029	-	-
Encrypted Contract or Group Number	20	A	-	-	-	T036	E028	-	-
End Date of Coverage	8	N	-	-	-	-	E037	-	-
Grandfathered Plan Indicator	1	A	-	-	-	-	E044	-	-
Group ID	128	A	-	-	-	-	-	-	C008
Health Insurance Oversight System (HIOS) Number	20	A	-	-	-	-	E047	-	-
Medical Coverage Indicator	1	A	-	-	-	-	E030	-	-
Metal Level Plan Indicator	1	A	-	-	-	-	E050	-	-
Pharmacy Coverage Indicator	1	A	-	-	-	-	E031	-	-
Plan Liability	1	A	P047	-	-	-	E034	-	-
Plan ID	128	A	-	-	-	-	-	-	C009
Plan or Product ID Number	20	A	-	-	-	-	E045	-	-
Policy Type	1	A	-	-	-	-	E027	-	-
Product Type	1	A	P050	-	-	T033	E026	-	-
Start Date of Coverage	8	N	-	-	-	-	E036	-	-
Provider Characteristics									
Attending Practitioner Individual National Provider Identifier (NPI) Number	10	A	-	-	I082	-	-	-	-
Hospital/Facility Federal Tax ID	9	A	-	-	I009	-	-	-	-
Hospital/Facility Medicare Provider Number	6	A	-	-	I011	-	-	-	-
Hospital/Facility National Provider Identifier (NPI) Number	10	A	-	-	I010	-	-	-	-
Hospital/Facility Participating Provider Flag	1	A	-	-	I012	-	-	-	-
Indicator for Multi-Practitioner Health Care Organization	1	A	-	-	-	-	-	D013	-
Operating Practitioner Individual National Provider Identifier (NPI) Number	10	A	-	-	I083	-	-	-	-
Pharmacy NCPDP Number	7	A	-	R007	-	-	-	-	-
Pharmacy NPI Number	10	A	-	R031	-	-	-	-	-
Pharmacy Zip Code +4digit add-on code	10	A	-	R008	-	-	-	-	-
Practitioner Credential	5	A	-	-	-	-	-	D008	-
Practitioner DEA #	11	A	-	-	-	-	-	D012	-
Practitioner DEA Number	11	A	-	R009	-	-	-	-	-
Practitioner Federal Tax ID	9	A	P012	-	-	T011	-	-	-
Practitioner Individual National Provider Identifier (NPI) Number	10	A	-	-	-	-	-	D014	-
Practitioner Middle Initial	1	A	-	-	-	-	-	D006	-
Practitioner Name Suffix	4	A	-	-	-	-	-	D007	-

MCDB Field Index (In Alphabetical Order)

Field Name	Length	Type	Field ID						
			Professional	Pharmacy	Institutional	Dental	Eligibility	Provider	CRISP
Practitioner National Provider Identifier (NPI) Number used for Billing	10	A	P049	-	-	T032	-	-	-
Practitioner Organizational National Provider Identifier (NPI) Number	10	A	-	-	-	-	-	D015	-
Practitioner/Supplier Federal Tax ID	9	A	-	-	-	-	-	D003	-
Practitioner/Supplier First Name	19	A	-	-	-	-	-	D005	-
Practitioner/Supplier ID	11	A	-	-	-	-	-	D002	-
Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization	31	A	-	-	-	-	-	D004	-
Practitioner/Supplier Specialty – 1*	10	A	-	-	-	-	-	D009	-
Practitioner/Supplier Specialty – 2*	10	A	-	-	-	-	-	D010	-
Practitioner/Supplier Specialty – 3*	10	A	-	-	-	-	-	D011	-
Prescribing Practitioner Individual National Provider Identifier (NPI) Number	10	A	-	R021	-	-	-	-	-
Prescribing Provider ID	11	A	-	R032	-	-	-	-	-
Service Location Zip Code +4digit add-on code	10	A	P032	-	-	T020	-	-	-
Servicing Practitioner ID	11	A	P038	-	-	T022	-	-	-
Servicing Practitioner Individual National Provider Identifier (NPI) Number	10	A	P048	-	-	T031	-	-	-
Diagnosis Information									
Claim Related Condition	1	A	P011	-	-	T010	-	-	-
Diagnosis Code 1	7	A	P019	-	-	-	-	-	-
Diagnosis Code 2	7	A	P020	-	-	-	-	-	-
Diagnosis Code 3	7	A	P021	-	-	-	-	-	-
Diagnosis Code 4	7	A	P022	-	-	-	-	-	-
Diagnosis Code 5	7	A	P023	-	-	-	-	-	-
Diagnosis Code 6	7	A	P024	-	-	-	-	-	-
Diagnosis Code 7	7	A	P025	-	-	-	-	-	-
Diagnosis Code 8	7	A	P026	-	-	-	-	-	-
Diagnosis Code 9	7	A	P027	-	-	-	-	-	-
Diagnosis Code 10	7	A	P028	-	-	-	-	-	-
Diagnosis Code Indicator	1	A	P054	-	I021	-	-	-	-
Diagnosis Related Groups (DRGs) Number	3	A	-	-	I130	-	-	-	-
DRG Group Name	1	A	-	-	I131	-	-	-	-
DRG Group Version	2	A	-	-	I132	-	-	-	-
Other Diagnosis Code 1	7	A	-	-	I024	-	-	-	-
Other Diagnosis Code 1 present on Admission 1	1	A	-	-	I025	-	-	-	-
Other Diagnosis Code 2	7	A	-	-	I026	-	-	-	-

MCDB Field Index (In Alphabetical Order)

Field Name	Length	Type	Field ID						
			Professional	Pharmacy	Institutional	Dental	Eligibility	Provider	CRISP
Other Diagnosis Code 2 present on Admission 2	1	A	-	-	I027	-	-	-	-
Other Diagnosis Code 3	7	A	-	-	I028	-	-	-	-
Other Diagnosis Code 3 present on Admission 3	1	A	-	-	I029	-	-	-	-
Other Diagnosis Code 4	7	A	-	-	I030	-	-	-	-
Other Diagnosis Code 4 present on Admission 4	1	A	-	-	I031	-	-	-	-
Other Diagnosis Code 5	7	A	-	-	I032	-	-	-	-
Other Diagnosis Code 5 present on Admission 5	1	A	-	-	I033	-	-	-	-
Other Diagnosis Code 6	7	A	-	-	I034	-	-	-	-
Other Diagnosis Code 6 present on Admission 6	1	A	-	-	I035	-	-	-	-
Other Diagnosis Code 7	7	A	-	-	I036	-	-	-	-
Other Diagnosis Code 7 present on Admission 7	1	A	-	-	I037	-	-	-	-
Other Diagnosis Code 8	7	A	-	-	I038	-	-	-	-
Other Diagnosis Code 8 present on Admission 8	1	A	-	-	I039	-	-	-	-
Other Diagnosis Code 9	7	A	-	-	I040	-	-	-	-
Other Diagnosis Code 9 present on Admission 9	1	A	-	-	I041	-	-	-	-
Other Diagnosis Code 10	7	A	-	-	I042	-	-	-	-
Other Diagnosis Code 10 present on Admission 10	1	A	-	-	I043	-	-	-	-
Other Diagnosis Code 11	7	A	-	-	I044	-	-	-	-
Other Diagnosis Code 11 present on Admission 11	1	A	-	-	I045	-	-	-	-
Other Diagnosis Code 12	7	A	-	-	I046	-	-	-	-
Other Diagnosis Code 12 present on Admission 12	1	A	-	-	I047	-	-	-	-
Other Diagnosis Code 13	7	A	-	-	I048	-	-	-	-
Other Diagnosis Code 13 present on Admission 13	1	A	-	-	I049	-	-	-	-
Other Diagnosis Code 14	7	A	-	-	I050	-	-	-	-
Other Diagnosis Code 14 present on Admission 14	1	A	-	-	I051	-	-	-	-
Other Diagnosis Code 15	7	A	-	-	I052	-	-	-	-
Other Diagnosis Code 15 present on Admission 15	1	A	-	-	I053	-	-	-	-
Other Diagnosis Code 16	7	A	-	-	I054	-	-	-	-
Other Diagnosis Code 16 present on Admission 16	1	A	-	-	I055	-	-	-	-
Other Diagnosis Code 17	7	A	-	-	I056	-	-	-	-
Other Diagnosis Code 17 present on Admission 17	1	A	-	-	I057	-	-	-	-
Other Diagnosis Code 18	7	A	-	-	I058	-	-	-	-
Other Diagnosis Code 18 present on Admission 18	1	A	-	-	I059	-	-	-	-
Other Diagnosis Code 19	7	A	-	-	I060	-	-	-	-
Other Diagnosis Code 19 present on Admission 19	1	A	-	-	I061	-	-	-	-
Other Diagnosis Code 20	7	A	-	-	I062	-	-	-	-

MCDB Field Index (In Alphabetical Order)

Field Name	Length	Type	Field ID						
			Professional	Pharmacy	Institutional	Dental	Eligibility	Provider	CRISP
Other Diagnosis Code 20 present on Admission 20	1	A	-	-	I063	-	-	-	-
Other Diagnosis Code 21	7	A	-	-	I064	-	-	-	-
Other Diagnosis Code 21 present on Admission 21	1	A	-	-	I065	-	-	-	-
Other Diagnosis Code 22	7	A	-	-	I066	-	-	-	-
Other Diagnosis Code 22 present on Admission 22	1	A	-	-	I067	-	-	-	-
Other Diagnosis Code 23	7	A	-	-	I068	-	-	-	-
Other Diagnosis Code 23 present on Admission 23	1	A	-	-	I069	-	-	-	-
Other Diagnosis Code 24	7	A	-	-	I070	-	-	-	-
Other Diagnosis Code 24 present on Admission 24	1	A	-	-	I071	-	-	-	-
Other Diagnosis Code 25	7	A	-	-	I072	-	-	-	-
Other Diagnosis Code 25 present on Admission 25	1	A	-	-	I073	-	-	-	-
Other Diagnosis Code 26	7	A	-	-	I074	-	-	-	-
Other Diagnosis Code 26 present on Admission 26	1	A	-	-	I075	-	-	-	-
Other Diagnosis Code 27	7	A	-	-	I076	-	-	-	-
Other Diagnosis Code 27 present on Admission 27	1	A	-	-	I077	-	-	-	-
Other Diagnosis Code 28	7	A	-	-	I078	-	-	-	-
Other Diagnosis Code 28 present on Admission 28	1	A	-	-	I079	-	-	-	-
Other Diagnosis Code 29	7	A	-	-	I080	-	-	-	-
Other Diagnosis Code 29 present on Admission 29	1	A	-	-	I081	-	-	-	-
Primary Diagnosis	7	A	-	-	I022	-	-	-	-
Primary Diagnosis Present on Admission	1	A	-	-	I023	-	-	-	-
Procedure Information									
CPT Category II Code 1	5	A	P055	-	-	-	-	-	-
CPT Category II Code 2	5	A	P056	-	-	-	-	-	-
CPT Category II Code 3	5	A	P057	-	-	-	-	-	-
CPT Category II Code 4	5	A	P058	-	-	-	-	-	-
CPT Category II Code 5	5	A	P059	-	-	-	-	-	-
Dental Quadrant – 1	2	A	-	-	-	T066	-	-	-
Dental Quadrant – 2	2	A	-	-	-	T067	-	-	-
Dental Quadrant – 3	2	A	-	-	-	T068	-	-	-
Dental Quadrant – 4	2	A	-	-	-	T069	-	-	-
Modifier I	2	A	P036	-	-	-	-	-	-
Modifier II	2	A	P037	-	-	-	-	-	-
Other Procedure Code 2	7	A	-	-	I088	-	-	-	-
Other Procedure Code 3	7	A	-	-	I091	-	-	-	-
Other Procedure Code 4	7	A	-	-	I094	-	-	-	-

MCDB Field Index (In Alphabetical Order)

Field Name	Length	Type	Field ID						
			Professional	Pharmacy	Institutional	Dental	Eligibility	Provider	CRISP
Other Procedure Code 5	7	A	-	-	I097	-	-	-	-
Other Procedure Code 6	7	A	-	-	I100	-	-	-	-
Other Procedure Code 7	7	A	-	-	I103	-	-	-	-
Other Procedure Code 8	7	A	-	-	I106	-	-	-	-
Other Procedure Code 9	7	A	-	-	I109	-	-	-	-
Other Procedure Code 10	7	A	-	-	I112	-	-	-	-
Other Procedure Code 11	7	A	-	-	I115	-	-	-	-
Other Procedure Code 12	7	A	-	-	I118	-	-	-	-
Other Procedure Code 13	7	A	-	-	I121	-	-	-	-
Other Procedure Code 14	7	A	-	-	I124	-	-	-	-
Other Procedure Code 15	7	A	-	-	I127	-	-	-	-
Principal Procedure Code 1	7	A	-	-	I085	-	-	-	-
Procedure Code	6*	A	P035	-	-	T021	-	-	-
Procedure Code 1 Modifier I	2	A	-	-	I086	-	-	-	-
Procedure Code 1 Modifier II	2	A	-	-	I087	-	-	-	-
Procedure Code 2 Modifier I	2	A	-	-	I089	-	-	-	-
Procedure Code 2 Modifier II	2	A	-	-	I090	-	-	-	-
Procedure Code 3 Modifier I	2	A	-	-	I092	-	-	-	-
Procedure Code 3 Modifier II	2	A	-	-	I093	-	-	-	-
Procedure Code 4 Modifier I	2	A	-	-	I095	-	-	-	-
Procedure Code 4 Modifier II	2	A	-	-	I096	-	-	-	-
Procedure Code 5 Modifier I	2	A	-	-	I098	-	-	-	-
Procedure Code 5 Modifier II	2	A	-	-	I099	-	-	-	-
Procedure Code 6 Modifier I	2	A	-	-	I101	-	-	-	-
Procedure Code 6 Modifier II	2	A	-	-	I102	-	-	-	-
Procedure Code 7 Modifier I	2	A	-	-	I104	-	-	-	-
Procedure Code 7 Modifier II	2	A	-	-	I105	-	-	-	-
Procedure Code 8 Modifier I	2	A	-	-	I107	-	-	-	-
Procedure Code 8 Modifier II	2	A	-	-	I108	-	-	-	-
Procedure Code 9 Modifier I	2	A	-	-	I110	-	-	-	-
Procedure Code 9 Modifier II	2	A	-	-	I111	-	-	-	-
Procedure Code 10 Modifier I	2	A	-	-	I113	-	-	-	-
Procedure Code 10 Modifier II	2	A	-	-	I114	-	-	-	-
Procedure Code 11 Modifier I	2	A	-	-	I116	-	-	-	-
Procedure Code 11 Modifier II	2	A	-	-	I117	-	-	-	-
Procedure Code 12 Modifier I	2	A	-	-	I119	-	-	-	-

MCDB Field Index (In Alphabetical Order)

Field Name	Length	Type	Field ID						
			Professional	Pharmacy	Institutional	Dental	Eligibility	Provider	CRISP
Procedure Code 12 Modifier II	2	A	-	-	I120	-	-	-	-
Procedure Code 13 Modifier I	2	A	-	-	I122	-	-	-	-
Procedure Code 13 Modifier II	2	A	-	-	I123	-	-	-	-
Procedure Code 14 Modifier I	2	A	-	-	I125	-	-	-	-
Procedure Code 14 Modifier II	2	A	-	-	I126	-	-	-	-
Procedure Code 15 Modifier I	2	A	-	-	I128	-	-	-	-
Procedure Code 15 Modifier II	2	A	-	-	I129	-	-	-	-
Procedure Code Indicator	1	A	-	-	I084	-	-	-	-
Tooth – 1 Surface – 1	5	A	-	-	-	T039	-	-	-
Tooth – 1 Surface – 2	5	A	-	-	-	T040	-	-	-
Tooth – 1 Surface – 3	5	A	-	-	-	T041	-	-	-
Tooth – 1 Surface – 4	5	A	-	-	-	T042	-	-	-
Tooth – 1 Surface – 5	5	A	-	-	-	T043	-	-	-
Tooth – 1 Surface – 6	5	A	-	-	-	T044	-	-	-
Tooth – 2 Surface – 1	5	A	-	-	-	T046	-	-	-
Tooth – 2 Surface – 2	5	A	-	-	-	T047	-	-	-
Tooth – 2 Surface – 3	5	A	-	-	-	T048	-	-	-
Tooth – 2 Surface – 4	5	A	-	-	-	T049	-	-	-
Tooth – 2 Surface – 5	5	A	-	-	-	T050	-	-	-
Tooth – 2 Surface – 6	5	A	-	-	-	T051	-	-	-
Tooth – 3 Surface – 1	5	A	-	-	-	T053	-	-	-
Tooth – 3 Surface – 2	5	A	-	-	-	T054	-	-	-
Tooth – 3 Surface – 3	5	A	-	-	-	T055	-	-	-
Tooth – 3 Surface – 4	5	A	-	-	-	T056	-	-	-
Tooth – 3 Surface – 5	5	A	-	-	-	T057	-	-	-
Tooth – 3 Surface – 6	5	A	-	-	-	T058	-	-	-
Tooth – 4 Surface – 1	5	A	-	-	-	T060	-	-	-
Tooth – 4 Surface – 2	5	A	-	-	-	T061	-	-	-
Tooth – 4 Surface – 3	5	A	-	-	-	T062	-	-	-
Tooth – 4 Surface – 4	5	A	-	-	-	T063	-	-	-
Tooth – 4 Surface – 5	5	A	-	-	-	T064	-	-	-
Tooth – 4 Surface – 6	5	A	-	-	-	T065	-	-	-
Tooth Number/Letter – 1	2	A	-	-	-	T038	-	-	-
Tooth Number/Letter – 2	2	A	-	-	-	T045	-	-	-
Tooth Number/Letter – 3	2	A	-	-	-	T052	-	-	-
Tooth Number/Letter – 4	2	A	-	-	-	T059	-	-	-

MCDB Field Index (In Alphabetical Order)

Field Name	Length	Type	Field ID						
			Professional	Pharmacy	Institutional	Dental	Eligibility	Provider	CRISP
Claim/Service Information									
Assignment of Benefits	1	A	P053	-	-	-	-	-	-
Claim Adjudication Date	8	N	P061	R033	I168	T076	-	-	-
Claim Control Number	23	A	P015	-	I013	T014	-	-	-
Claim Line Number	4	A	P062	R034	I169	T077	-	-	-
Claim Line Type	1	A	P064	R036	I171	T079	-	-	-
Claim Paid Date	8	N	P016	-	I014	T015	-	-	-
Date Appliance Placed	8	N	-	-	-	T071	-	-	-
Date Filled	8	N	-	R015	-	-	-	-	-
Date of Admission or Start of Service	8	N	-	-	I019	-	-	-	-
Date of Discharge or End of Service	8	A	-	-	I020	-	-	-	-
Date of Prior Placement	8	N	-	-	-	T074	-	-	-
Date Prescription Written	8	N	-	R016	-	-	-	-	-
Drug Compound	1	A	-	R012	-	-	-	-	-
Drug Quantity	5	N	P068	R013	-	-	-	-	-
Drug Supply	3	N	-	R014	-	-	-	-	-
Fill Number	2	A	-	R010	-	-	-	-	-
Flag for Former Claim Number Use	1	A	P066	R038	I173	T081	-	-	-
Former Claim Number	23	A	P065	-	I172	T080	-	-	-
Former Prescription Claim Number	23	A	-	R037	-	-	-	-	-
Months of Treatment Remaining	2	N	-	-	-	T072	-	-	-
NDC Number	11	A	P067	R011	-	-	-	-	-
Orthodontics Treatment	1	A	-	-	-	T070	-	-	-
Participating Provider Status	1	A	P013	-	-	T012	-	-	-
Patient Discharge Status	2	A	-	-	I018	-	-	-	-
Place of Service	2	A	P031	-	-	T019	-	-	-
Point of Origin for Admission or Visit	1	A	-	-	I017	-	-	-	-
Prescription Claim Control Number	15	A	-	R019	-	-	-	-	-
Prescription Claim Paid Date	8	N	-	R020	-	-	-	-	-
Prosthesis Replacement	1	A	-	-	-	T073	-	-	-
Revenue Code	4	A	-	-	I144	-	-	-	-
Record Type	2	A	-	-	I015	-	-	-	-
Record Status	1	A	P014	-	-	T013	-	-	-
Service From Date	8	N	P029	-	-	T017	-	-	-
Service Thru Date	8	N	P030	-	-	T018	-	-	-
Service Unit Indicator	1	A	P033	-	-	-	-	-	-

MCDB Field Index (In Alphabetical Order)

Field Name	Length	Type	Field ID						
			Professional	Pharmacy	Institutional	Dental	Eligibility	Provider	CRISP
Type of Admission	1	A	-	-	I016	-	-	-	-
Type of Bill	3	A	-	-	I140	-	-	-	-
Units of Service	3	A	P034	-	-	-	-	-	-
Version Number	4	A	P063	R035	I170	T078	-	-	-
Financial Information									
Allowed Amount	9	N	P040	R039	I134	T024	-	-	-
Amount Paid by Other Insurance	9	N	P069	R041	I139	T082	-	-	-
Billed Charge	9	N	P039	R017	I133	T023	-	-	-
Other Patient Obligations	9	N	P046	R024	-	T030	-	-	-
Patient Coinsurance or Patient Co-payment	9	N	P045	R023	-	T029	-	-	-
Patient Deductible	9	N	P044	R022	-	T028	-	-	-
Reimbursement Amount	9	N	P041	R018	I135	T025	-	-	-
Total Other Patient Obligations	9	N	-	-	I138	-	-	-	-
Total Patient Coinsurance or Patient Co-payment	9	N	-	-	I137	-	-	-	-
Total Patient Deductible	9	N	-	-	I136	-	-	-	-

*Procedure Code is 5 characters in length in the Dental Services file.