State of California
Office of Administrative Law

In re:
Department of Health Care Access and Information

Regulatory Action:

Title 22, California Code of Regulations

Amend sections: 97300, 97314, 97331, 97332, 97340, 97341, 97342, 97344, 97346, 97350, 97351, 97360, 97370

NOTICE OF APPROVAL OF REGULATORY ACTION

Government Code Section 11349.3

OAL Matter Number: 2026-0121-01

OAL Matter Type: Regular (S)

This rulemaking action by the Department of Health Care Access and Information amends regulations for the Health Care Payments Data Program to update data submission requirements, including the adoption of the Common Data Layout for All-Payer Claims Databases, Version 4.0.1, released February 2025.

OAL approves this regulatory action pursuant to section 11349.3 of the Government Code. This regulatory action becomes effective on 3/4/2026.

Date: March 4, 2026

Anna Thomas
Attorney

For: Kenneth J. Pogue
Director

Original: Elizabeth Landsberg, Director
Copy: Sherry Mung

STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

REGULAR

STD. 400 (REV. 10/2019)

For use by Secretary of State only

ENDORSED - FILED
in the office of the Secretary of State
of the State of California

MAR 04 2026

2:05 PM

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-2025-0902-04	2026-0121-01S	

For use by Office of Administrative Law (OAL) only

OFFICE OF ADMIN. LAW
2026 JAN 21 PM 12:02

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY
California Department of Health Care Access and Information

AGENCY FILE NUMBER (If any)

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)
Health Care Payments Data Program Data Collection Updates

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) **(Including title 26, if toxics related)**

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT

AMEND
97300, 97314, 97331, 97332, 97340, 97341, 97342, 97344, 97346, 97350, 97351, 97360, & 97370

TITLE(S)
22

REPEAL

3. TYPE OF FILING

- ☒ Regular Rulemaking (Gov. Code §11346)
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ File & Print
- ☐ Print Only
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Other (Specify) _____

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)
November 3, 2025, through November 18, 2025

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)
☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a)) ☒ Effective on filing with Secretary of State ☐ §100 Changes Without Regulatory Effect ☐ Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY
☐ Department of Finance (Form STD. 399) (SAM §6660) ☐ Fair Political Practices Commission ☐ State Fire Marshal
☐ Other (Specify) _____

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Sherry Mung	(916) 326-3939		sherry.mung@hcai.ca.gov

8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

SIGNATURE OF AGENCY HEAD OR DESIGNEE
J. Scott Christman

DATE
01/20/2026

TYPED NAME AND TITLE OF SIGNATORY
J. Scott Christman, Chief Deputy DIrector

For use by Office of Administrative Law (OAL) only
ENDORSED APPROVED
MAR 04 2026
Office of Administrative Law

DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
HEALTH CARE PAYMENTS DATA PROGRAM
DATA COLLECTION REGULATIONS

CALIFORNIA CODE OF REGULATIONS TITLE 22
Division 7. Health Planning and Facility Construction

Chapter 11. Health Care Payments Data Program
Article 1. Chapter Definitions

§ 97300. Definitions.

The following definitions shall apply to the regulations contained in this Chapter:

(a) "APCD-CDL™" means one of the following:

PER AGENCY REQUEST KDH

(1) For data files submitted or resubmitted pursuant to this Chapter on or before March 30, 2026, the Common Data Layout for All-Payer Claims Databases, Version 3.0.1, released April 1, 2023, as developed by the University of New Hampshire and the National Association of Health Data Organizations (NAHDO), and hereby incorporated by reference. This document is available through the APCD Council website.; or

(2) For data files submitted or resubmitted pursuant to this Chapter on or after March 31, 2026, the Common Data Layout for All-Payer Claims Databases, Version 4.0.1, released February 2025, as developed by the University of New Hampshire and NAHDO, and hereby incorporated by reference. This document is available through the APCD Council website.

(b) "Data portal" means the secure ~~data submission mechanism~~ website through which plans register to submit data and data files ~~are~~ can be submitted to the system. The data portal is available via the Department's website.

(c) "Data Submission Guide" means one of the following:

PER AGENCY REQUEST KDH

(1) For registrations and data files submitted or resubmitted pursuant to this Chapter on or before March 30, 2026, the Health Care Payments Data Program: Data Submission Guide, Version 3.0, revised on October 28, 2024, and hereby incorporated by reference. The Data Submission Guide is available on, and may be downloaded from, the Department's website.; or

(2) For registrations and data files submitted or resubmitted pursuant to this Chapter on or after March 31, 2026, the Health Care Payments Data

Program: Data Submission Guide, Version 4.0, revised on October 31, 2025, and hereby incorporated by reference. The Data Submission Guide is available on, and may be downloaded from, the Department's website.

(d) "Delegated submitter" means an entity identified pursuant to Section 97318 as responsible for submitting data to the system on behalf of a plan.

(e) "Dental Data" means dental claims files as described in Section 97342, data for members who are exclusively enrolled for dental services, and data for providers who exclusively provided dental services.

(f) "Dental Plan" means a specialized health care service plan covering dental services only, a dental-only insurance plan, or a public self-insured plan covering dental services only.

(g) "Department" means the Department of Health Care Access and Information.

(h) "Designated submitter representative" means an individual or individuals designated by a registered submitter to submit data on behalf of the registered submitter and receive all communications from the System and the Department regarding data submissions.

(i) "Director" means the Director of the Department of Health Care Access and Information.

(j) "Health insurer" means an insurer licensed to provide health insurance, as defined in Section 106 of the Insurance Code, and an insurer offering specialized health insurance offering pharmacy, behavioral health (psychological), or dental services. Insurers providing only other specialized health insurance, or stop-loss insurance, student health insurance, supplemental insurance (including Medicare supplemental insurance), or discount-only insurance, are not considered health insurers.

(k) "Health plan" means a health care service plan as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or a specialized health care service plan offering pharmacy, behavioral health (psychological), or dental services. "Health plan" does not include a health care service plan that holds a restricted or limited license only under the Knox-Keene Health Service Plan Act of 1975. Student health plans and supplemental plans (including Medicare supplemental coverage) are not considered health plans.

(l) "Member" means a person who is enrolled in or covered by a health plan, health insurer, or public self-insured plan.

(m) "NCP Data Layout™" means the Data Layout for Non-Claims Payments, Version 1.0, released April 2024 as developed by the APCD Council, NAHDO, and University of

New Hampshire, and hereby incorporated by reference. The NCP Data Layout™ applies to data files submitted or resubmitted pursuant to this Chapter on or before March 30, 2026. This document is available through the NAHDO website.

(n) "Plan" means a non-exempt health plan, health insurer, or public self-insured plan; and any voluntarily participating entity.

(o) "Program" means the Health Care Payments Data Program established pursuant to Health and Safety Code Section 127671.1.

(p) "Public self-insured plan" means:

(1) A self-insured plan subject to Health and Safety Code Section 1349.2, or

(2) A state entity, city, county, or other political subdivision of the state, or a public joint labor management trust, that offers self-insured or multiemployer-insured plans that pay for or reimburse any part of the cost of health care services.

(q) "Qualified Health Plan" means a Qualified Health Plan offered by the California Health Benefit Exchange.

(r) "Registered submitter" means a plan that has registered to submit data to the system. An entity that is a delegated submitter under Section 97318 and has registered to submit data will be considered a registered submitter.

(s) "System" means the Health Care Payments Data System.

(t) "Voluntarily participating entity" means an entity that chooses to voluntarily submit data to the Program, has been approved by the Department to submit data, and is one of the following business types:

(1) A self-insured employer that is not subject to Health and Safety Code Section 1349.2.

(2) A multiemployer self-insured plan that is responsible for paying for health care services provided to beneficiaries.

(3) The trust administrator for a multiemployer self-insured plan.

(4) A provider, as defined in Health and Safety Code Section 1367.50(b)(2), that is a hospital or clinic.

(5) A supplier, as defined in Health and Safety Code Section 1367.50(b)(3), that has an independent scope of practice and submits claims electronically.

(6) A health plan or health insurer exempt from the requirements of this Chapter.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671, 127671.1, 127673, 127673.1 and 127673.2, Health and Safety Code.

Article 3. General Provisions

§ 97314. Qualified Health Plans.

A Qualified Health Plan that has been granted an exemption from reporting information to the Program by the California Health Benefit Exchange is not required to register with or submit data files to the ~~data portal~~ Program.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1 and 127673, Health and Safety Code.

Article 4. Data Portal Registration

§ 97331. Submitter Registration Requirement.

(a) If a plan is submitting data directly to the system, the plan shall also register ~~to submit data through the data portal~~ as a data submitter after it has registered with the Program pursuant to Section 97330.

(b) After a plan registers with the Program pursuant to Section 97330, each of its delegated submitters, if any, shall register separately from the plan as a data submitter ~~to submit data through the data portal~~.

(c) Plans and delegated submitters shall register under this Section each year by the last calendar day of February.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, 127673 and 127673.1, Health and Safety Code.

§ 97332. Registration Process.

(a) For registrations under Sections 97330 and 97331, plans and any delegated submitters must do all the following:

(1) register through the data portal and comply with the data portal requirements in the Data Submission Guide;

(2) follow the Data Submission Guide's registration instructions; and

(3) provide all required information as specified in the Data Submission Guide.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, 127673 and 127673.1, Health and Safety Code.

Article 5. Data File Submission

§ 97340. Data Submission Methods.

(a) Plans shall electronically submit data files ~~through the data portal~~ to the Program.

(b) Plans and delegated submitters shall comply with the data submission requirements in the Data Submission Guide, and if submitting data files through the data portal, the Data Submission Guide's data portal requirements.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, 127673, and 127673.1, Health and Safety Code.

§ 97341. Data Submission Due Dates.

(a) Plans shall submit the monthly data files identified in Section 97342 by the first business day of the second month after the report month, except the monthly data file submissions for the January 2026 and February 2026 reporting periods shall be submitted no earlier than March 31, 2026, and by April 13, 2026.

(b) Plans shall submit the annual data files identified in Section 97342 by the last day of September of the year following the report year. A report year is a calendar year.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1 and 127673, Health and Safety Code.

§ 97342. Data File Contents.

(a) The following monthly data files, as specified in the Data Submission Guide in conjunction with the APCD-CDL™ and, for data files submitted or resubmitted on or before March 30, 2026, the NCP Data Layout™, shall be submitted.

(1) Member Eligibility File (ME) -- contains demographic information for each individual member residing in California, regardless of whether the member utilized services during the reporting period.

(2) Medical Claims File (MC) -- contains service-level medical claims and encounter data processed during the reporting period, that were not fully denied, except as prohibited by federal or state law.

(3) Pharmacy Claims File (PC) -- contains detailed pharmacy claims and encounter data processed during the reporting period, that were not fully denied, except as prohibited by federal or state law.

(4) Dental Claims File (DC) -- contains service-level dental claims and encounter data processed during the reporting period, that were not fully denied, except as prohibited by federal or state law.

(5) Provider File (PV) -- contains demographic-type data on every provider included on the ME, MC, PC, or DC files during the reporting period.

(6) Capitation File (CF) -- contains data on payments for member-attributable services under a capitation arrangement.

(b) The following annual data files, as specified in the Data Submission Guide in conjunction with the APCD-CDL™ and, for data files submitted or resubmitted on or before March 30, 2026, the NCP Data Layout™, shall be submitted.

(1) Annual Payment File (AP) -- contains data on contractually based non-claims payments.

(2) Pharmacy Rebate File (PR) -- contains data on prescription drug rebate payments.

(c) Files shall exclude data for any members who are exclusively enrolled in Medi-Cal or one of the following types of coverage:

(1) Supplemental (including Medicare supplemental).

(2) Student health.

(3) Chiropractic-only.

(4) Acupuncture-only.

(5) Vision-only.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, 127673 and 127673.1, Health and Safety Code.

§ 97344. Data File Technical Requirements.

Data files shall comply with file format, technical specifications, and other standards specified in the Data Submission Guide, the APCD-CDL™, and, for data files submitted or resubmitted on or before March 30, 2026, the NCP Data Layout™.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, 127673, and 127673.1, Health and Safety Code.

§ 97346. Submission Completion.

If a registered plan has identified one or more delegated submitters to submit information directly to the Program ~~data portal~~ on behalf of the plan, the plan's data submission shall not be considered complete until all required files have been received.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, 127673, and 127673.1 Health and Safety Code.

Article 5.5 Special Rules for Program Opening and Historical Data Submission

§ 97350. Preparation for Historical Data Submission.

(a) Each registered submitter shall use the test function to prepare for historical data file submission.

(b) Dental plans shall successfully complete the testing process by July 31, 2024.

(c) Before plans submit historical data files under Section 97351~~(b)~~(a)(2) or ~~(c)~~(a)(3), plans and delegated submitters shall comply with the registration and testing requirements in Section 4 of the Data Submission Guide.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, and 127673, Health and Safety Code.

§ 97351. Historical Data Files.

~~(a) All plans shall submit dental data in accordance with Sections 97342 and 97344 for the time period from June 29, 2017 through December 2021 by October 31, 2024.~~

~~(b) All plans shall submit Capitation Files in accordance with Sections 97342 and 97344 for the time period from June 29, 2017 through July 31, 2026 by September 1, 2026.~~

~~(c) All plans shall submit Annual Payment Files and Pharmacy Rebate Files in accordance with Sections 97342 and 97344 for the time period from June 29, 2017 through December 31, 2024 by July 31, 2026.~~

(a) To the extent plans have the following data, plans shall submit the following:

(1) Dental data in accordance with Sections 97342 and 97344 for the time period from June 29, 2017 through December 2021 by October 31, 2024.

(2) Capitation Files in accordance with Sections 97342 and 97344 for the time period from June 29, 2017 through July 31, 2026 by September 1, 2026.

(3) Annual Payment Files and Pharmacy Rebate Files in accordance with Sections 97342 and 97344 for the time period from June 29, 2017 through December 31, 2024 by July 31, 2026.

(b) A plan that does not have data described in subsection (a) to submit shall report this to the Department by email at HPD@hcai.ca.gov at least thirty (30) days before the due date for that data. The plan shall describe the data it does not have, the time period for which it does not have the data, and why it does not have the data in its report.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1 and 127673, Health and Safety Code.

Article 6. Data Acceptance and Correction

§ 97360. Data Acceptance.

(a) Data files that are submitted to the Program ~~data portal~~ but do not meet the requirements ~~file intake specifications~~ detailed in the Data Submission Guide will not be accepted.

(b) Registered submitters will be notified within 3 business days of submission whether a data file has been accepted or rejected.

Note: Authority cited: Sections 127673 and 127673.4, Health and Safety Code. Reference: Sections 127671.1, 127673.1, and 127673.4, Health and Safety Code.

Article 7. Variances

§ 97370. Requesting a Variance.

(a) A plan that is unable to submit data files meeting the requirements ~~file intake specifications~~ detailed in the Data Submission Guide may request a temporary variance to those requirements.

(b) Variance requests shall be submitted through the data portal, and shall clearly identify the current issues, the plan for correction, and the anticipated date of correction.

(c) The Department shall either approve or disapprove variance requests within 30 calendar days of the date the request was submitted.

Note: Authority cited: Sections 127673 and 127673.4, Health and Safety Code. Reference: Sections 127671.1, 127673.1, and 127673.4, Health and Safety Code.

State of California

Department of Health Care Access and Information

Health Care Payments Data Program

Data Submission Guide

~~October 28, 2024~~October31, 2025

Version ~~3.0~~4.0

Table of Contents

Document Change Log

Version	Date	Changes

4.0	October 31, 2025	Updated to incorporate use of APCD-CDL™ Version 4.0.1
		• Table of Contents – Renamed Section 5 as "Data Portal Requirements".
		  • Added section 6: "File Submissions"
		  • Added "Data Submission and Encryption Requirements" as Section 6.1
		  • Moved "File Intake Specifications" to Section 6.2
		• Introduction – Updated for standard use of APCD-CDL™ Version 4.0.1
		  • Removed reference to File Intake Specifications for APCD-CDL™ Version 4.0.1 file types
		  • Updated version implementation date to March 31, 2026.
		  • Added instructions to defer to Data Submission Guide where field requirements differ compared to APCD-CDL™ Version 4.0.1
		• Added registration requirements for submitters who submit data via Secure File Transfer Protocol to Section 2.2
		• Added credential requirements for submitters using HPD Data Portal to Section 2.2
		• Included HPD Data Portal requirements in Section 5.
		• Added requirements for use of APCD-CDL™ Version 4.0.1 to File Intake Specifications in Section 6.2

		• APCD-CDL™ Version 4.0.1 includes non-claims payment files (Annual Payment, Pharmacy Rebate, Capitation) • Updated table headers for Annual Payment File, Pharmacy Rebate File, and Capitation File to reflect incorporation into APCD-CDL™ • Added instructions to defer to Data Submission Guide instructions for fields CDLPR005 and CDLCF019 • File Header - Updated version reference in notes from "3.0.1" to "4.0.1" in CDLHD010 • File Trailer - Updated Control total references (CDLAP016, CDLPR011, CDLCF019) in CDLTR007 to reflect changes in APCD-CDL™ Version 4.0.1 • Annual Payment file - Updated notes for CDLPA014 and CDLPA015 • Updated name change and removed notes in Pharmacy Claims (CDLPC030) • Updated Pharmacy Rebates File Field CDLPR005 to note difference from APCD-CDL™ Version 4.0.1 instructions and require 11 digit National Drug Code • Updated Capitation File Field CDLCF019 to note difference from APCD-CDL™ Version 4.0.1 instructions and to require reporting of unrounded amount • Removed notes that reference NCP Data Layout™ from Annual Payment File, Capitation File, and Pharmacy Rebate File tables in Section 6
3.0	October 28, 2024	Added new section 4 which describes requirements for registration and testing for historical NCP Data Files. Applied minor grammar corrections to file names.

		NCP Data Layout™ Version 1.0 File Specifications. • Introduction – Added link to NCP Data Layout™, removed date-dependent usage of v2.1 vs 3.0.1 • Submitter Registration – Added NCP data files • File Intake Specifications – Specified which files will use APCD-CDL™ v3.0.1 and which files will use NCP Data Layout™ v1.0 • File Header – Updated possible values for CDLHD005 • File trailer – Updated possible values for CDLTR005 and CDLTR007 • Removed typo entry for Dental Claims (CDLDC156) • Added file tables for Annual Payment file, Pharmacy Rebate file and Capitation file
2.0	July 17, 2023	Updated to use APCD-CDL™ version 3.0.1: • Member Gender was updated to Member Sex • Race fields updated to use the six-character concept code New additions to the eligibility file include: Member Gender Identity (CDLME081) and Member Sexual Orientation (CDLME082)
1.0	September 1, 2021	Initial publication.

1 Introduction

This Data Submission Guide (DSG) describes the requirements with which data submitted to the Health Care Payments Data (HPD) Program must comply. The Department of Health Care Access and Information (HCAI) maintains and updates these specifications, which are incorporated by reference in California's HPD Program regulations.

The HPD Program uses the Common Data Layout for All-Payer Claims Databases (APCD-CDL™), Version 4.0.1, released February 2025. Submitters are required to use this APCD-CDL™ standard to submit health care enrollment, cost, utilization, provider data, and Non-Claims Payment data to the HPD System.

~~following standards:~~

- ~~Common Data Layout for All-Payer Claims Databases (APCD-CDL™) for Eligibility, Medical Claims, Pharmacy Claims, Dental Claims and Provider files. The version used is 3.0.1 and was published on April 1, 2023.~~
- ~~NCP Data Layout™, A Data Layout for Non-Claims Payments for Annual Payments, Pharmacy Rebates, and Capitation files. The version used is 1.0 and was published April 2024.~~

For more information about the APCD-CDL™, visit the APCD Council's website (https://www.apcdcouncil.org/common-data-layout).

~~For more information about the NCP Data Layout™, visit the National Association of Health Data Organizations (NAHDO) website (https://nahdo.org/datalayouts).~~

The File Intake Specifications do not repeat content from the APCD-CDL™ ~~either of the standards~~, instead, the DSG offers additional detail for submissions to the HPD Program not covered in the APCD-CDL™~~these standard documents~~ (such as required and situational field designations). The DSG also has different submission requirements for fields CDLPR005 and CDLCF019 than the APCD-CDL™ (these differences are in the File Intake Specification section of this document). For these fields, the DSG supersedes the requirements in APCD-CDL™ version 4.0.1.

This version of the DSG is for HPD submissions or resubmissions on or after March 31, 2026, using APCD-CDL™ version 4.0.1.

PER AGENCY REQUEST KDH

2 Registration

Two different types of registration are required via the HPD portal: one for plans and one for submitters.

~~October 28, 2024~~October 31, 2025

A dental plan must complete its initial registration (both plan and submitter) with HPD by March 29, 2024.

2.1 Plan Registration

This includes any mandatory submitter, such as a health plan, insurer or public self-insured entity, and any voluntary submitter (directly or through an authorized agent of the voluntary submitter). For licensed entities such as health plans or insurers, the registration is at the license level.

Plan registration will take place during the month of January each year and by the last calendar day of January.

Each of these types of plans will provide the following information during the registration process:

- Legal entity name and address
- Type of entity: mandatory or voluntary, and whether: plan/insurer, public self-insured, private self-insured
- National Association of Insurance Commissioners (NAIC) Code
- Product type(s)
- License Type and License Number
- Lines of Business
- A regulatory contact (first and last name, phone, email and address)
- A business contact for submission issues (name, phone, email and address)
- If the plan will be submitting its own data, list the types of data files that will be submitted.
- If the plan is delegating submission, the plan shall provide a list of submitters, and the following information for each submitter:
    - Legal entity name
    - Contact information (name, title, phone, email and address)
    - The type of data files to be submitted

Upon approval of the registration, the registering entity will be notified and provided with a unique Payer Code that will be used in data submission to identify data they are responsible for. Submitted files that contain an invalid Payer Code will not be accepted.

2.2 Submitter Registration

Each entity who will submit data to HPD must register via the data portal. Plans who will submit data themselves (without any delegation) must also register as a submitter.

Submitter registration will take place each year after plan registration has been completed and by the last calendar day of February.

Each registering submitter must provide the following information to register:

- Legal entity name and address
- At least two designated submitter representatives (first and last name, title, phone, email and address)
- A list of all plans who they will submit data on behalf of. For each plan entity, the following information is required:
    - Payer Code and Name
    - A complete list of all data file types (Eligibility, Medical Claims, Pharmacy Claims, Dental Claims, Provider, Annual Payments, Pharmacy Rebates, and Capitation) they will submit for each Payer Code
- If submitting data outside of the data portal via secure file transfer protocol (SFTP):
    - Submitter's SFTP technical contact (first and last name, title, phone, email and address). This is the person who is responsible for the technical requirements of SFTP submission for submitter.
    - If submitter has a person responsible for facilitating exchanges between submitter's SFTP technical contact and HCAI or HCAI's data portal contractor, submitter' SFTP contact (first and last name, title, phone, email and address).

Upon approval of the registration, the registering submitter will be notified and provided with a unique Submitter Code that will be used in data submission to identify data they are responsible for. Submitted files that contain an invalid Submitter Code or invalid Payer Code/Submitter Code combination will not be accepted.

Additionally, upon approval of the registration, the registering submitter shall be required to create a password to access the data portal.

3 Test File Submission

Registered submitters shall submit test files through the HPD data portal. Test files are identified by CDLHD008 = "T".

4 Special Registration and Testing Requirements for Historical NCP Data Files

In this DSG, "NCP Data Files" means Capitation Files, Annual Payment Files, and Pharmacy Rebate Files.

Plans and delegated submitters must register and test as required in Sections 4.1 and 4.2 below before submitting historical NCP Data Files[1].

4.1 Registration Update

Before testing required by Section 4.2 of this DSG, plans and delegated submitters must do the following:

- Plans must update their 2025 Plan Registrations by identifying the entities that will submit their historical NCP data files. Plans must provide the information required by Section 2.1 of this DSG for these entities.
- Registered submitters which will submit historical NCP Data Files must update their 2025 Submitter Registrations. Registered submitters must provide the information required by Section 2.2 of this DSG regarding their historical NCP Data File submission(s).
- Delegated submitters which did not register as registered submitters in 2025 and which will submit historical NCP Data Files must register as a submitter under Section 2.2 of this DSG.

4.2 Testing

After registering under Section 4.1 of this DSG, registered submitters must:

- By September 1, 2025, submit at least one test file through the data portal for each historical NCP Data File type they will submit.
    - For example, if a registered submitter will submit historical Annual Payment Files and historical Capitation Files, it must submit at least one test Annual Payments File and one test Capitation File by September 1, 2025.
- By June 30, 2026, successfully complete testing for each historical NCP Data File type they will submit.

[1] Historical NCP Data File submission is required by California Code of Regulations, title 22, section 97351(b) and (c).

- "Successfully complete testing" means that the registered submitter, for each NCP Data File type it will submit, submitted a test file that was not rejected by HCAI. Reasons for rejection are stated in Section ~~5~~6 of this DSG.
- Registered submitters may need to submit multiple test files before successfully completing testing.

5 ~~File Intake Specifications~~ Data Portal Requirements

~~Plans will be assigned a Payer Code by HCAI during the registration process. Submitters will be assigned a Data Submitter Code. Both codes are required data elements within the submitted data files.~~

~~Each file submitted to the HPD System must contain a valid File Header and a valid File Trailer.~~

~~**Submitters must comply with the data definitions in the APCD-CDL™ Version 3.0.1 and the NCP Data Layout™ Version 1.0. The data elements in the following tables include those fields designated as "Required" and "Situational". All other data elements shall be populated with available data.**~~

~~The below files use APCD-CDL™ Version 3.0.1 as the standard.~~

- ~~File Header~~
- ~~File Trailer~~
- ~~Member Eligibility File~~
- ~~Medical Claims File~~
- ~~Pharmacy Claims File~~
- ~~Dental Claims File~~
- ~~Provider File~~

~~The below files use the NCP Data Layout™ Version 1.0 as the standard.~~

- ~~Annual Payment File~~
- ~~Pharmacy Rebate File~~
- ~~Capitation File~~

~~Files submitted to the HPD System will be either accepted or rejected. Reasons for rejection include the following:~~

- ~~Invalid file format, including layout, field lengths, or data types.~~
- ~~Eligibility records, medical claims, pharmacy claims, and dental claims for which paid dates or eligibility dates do not match the reporting period as indicated by the Period Beginning Date and Period Ending Date in the File Header.~~
- ~~Invalid values for required or situationally required data elements – unless a Data Variance has been approved by HCAI.~~
- ~~Other technical deficiencies related to file submission, storage, or processing.~~

~~Data elements designated in the following sections as "Required" must be populated at all times. Unless a variance has been registered and accepted for a specific field, failure to provide a valid value in a required field will result in the rejection of the submitted file.~~

~~Data elements designated in the following sections as "Situational" must be populated under specific circumstances. Unless a variance has been registered and accepted for a specific field, failure to provide a valid value in a situational field will result in the rejection of the submitted file if the situational circumstance is present. For example, the claims file data element "Admission Date" is designated as "Situational" and is required when the claim/encounter is "Inpatient".~~

~~**Only Required and Situational data elements are included in the following tables, however, all fields are required to be submitted if data is available.**~~

~~Data elements designated in the following sections as "Required" must be populated at all times, unless a variance has been registered and accepted for a specific field.~~

Plans and submitters shall comply with the following when using the data portal:

- Not infringe any intellectual property right that HCAI or HCAI's data portal contractor has in the data portal.
- Protect and keep confidential their passwords to the data portal.
- Not use and prevent the use of the data portal by its staff for purposes other than to comply with HPD requirements or other legal requirements.
- Immediately notify HCAI or HCAI's data portal contractor if the plan or submitter believes the data portal is not functioning properly for it to submit data, or that the data portal's security has been compromised, including, but not limited to, if the plan or delegated submitter's password was disclosed to or used by unauthorized entities.

- Immediately notify HCAI or HCAI's data portal contractor if the plan or submitter obtains access to another entity's data or data about patients, consumers, or providers in the data portal.
- Assist HCAI or HCAI's data portal contractor in investigating and resolving data portal failures or security issues.

6 File Submissions

6.1 Data Submission and Encryption Requirements

Data files shall be submitted either through the data portal or outside the data portal via Secure File Transfer Protocol (SFTP). A submitter's annual registration must be approved prior to data submission.

For both data portal and SFTP submissions, submitters must encrypt their data files using the OpenPGP encryption standard prior to submission. For more information on OpenPGP encryption, refer to https://openpgp.org.

For submissions through the data portal, submitters must create an OpenPGP key pair consisting of one public PGP key and one private PGP key. Submitters must exchange their respective public PGP keys with HCAI's data portal contractor.

For SFTP submissions, submitters must create two key pairs: an OpenPGP key pair consisting of one public PGP key and one private PGP key and a Secure Shell (SSH) key pair, consisting of one public SSH key and one private SSH key. Submitters must exchange their respective public PGP keys and public SSH keys with HCAI's data portal contractor.

For all submissions, submitters must encrypt the files using HCAI's data portal contractor's public PGP key with HCAI's data portal contractor identified as the recipient of the file. Submitters must also sign the encryption using the private PGP key with the submitter identified as the sender of the file.

Data files that do not comply with the above encryption or data submission requirements will be rejected.

6.2 File Intake Specifications

Plans will be assigned a Payer Code by HCAI during the registration process. Submitters will be assigned a Data Submitter Code. Both codes are required data elements within the submitted data files.

Each file submitted to the HPD System must contain a valid File Header and a valid File Trailer.

Submitters must comply with the data definitions in the APCD-CDL™ Version 4.0.1 unless stated otherwise in this DSG. The data elements in the following tables include those fields designated as "Required" and "Situational". All other data elements shall be populated with available data.

Files submitted to the HPD System will be either accepted or rejected. Reasons for rejection include the following:

- Invalid file format, including layout, field lengths, or data types.
- Eligibility records, medical claims, pharmacy claims, and dental claims for which paid dates or eligibility dates do not match the reporting period as indicated by the Period Beginning Date and Period Ending Date in the File Header.
- Invalid values for required or situationally required data elements – unless a Data Variance has been approved by HCAI.
- Other technical deficiencies related to file submission, storage, or processing.
- Files have data about non-California residents.

Data elements designated in the following sections as "Required" must be populated at all times. Unless a variance has been registered and accepted for a specific field, failure to provide a valid value in a required field will result in the rejection of the submitted file.

Data elements designated in the following sections as "Situational" must be populated under specific circumstances. Unless a variance has been registered and accepted for a specific field, failure to provide a valid value in a situational field will result in the rejection of the submitted file if the situational circumstance is present. For example, the claims file data element "Admission Date" is designated as "Situational" and is required when the claim/encounter is "Inpatient".

Only Required and Situational data elements are included in the following tables, however, all fields are required to be submitted if data is available.

Data elements designated in the following sections as "Required" must be populated at all times, unless a variance has been registered and accepted for a specific field. Submission requirements in the DSG for fields CDLPR005 and CDLCF019 supersede the requirements in APCD-CDL™ version 4.0.1.

~~5.1~~6.3 File Header

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLHD001	Record Type	Required	
CDLHD002	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLHD004	Data Submitter Name	Required	
CDLHD005	File Type	Required	ME = Member Eligibility MC = Medical Claims PC = Pharmacy Claims DC = Dental Claims PV = Provider File AP = Annual Payments PR = Pharmacy Rebates CF = Capitation File
CDLHD006	Period Beginning Date	Required	YYYYMMDD
CDLHD007	Period Ending Date	Required	YYYYMMDD
CDLHD008	Test File Flag	Required	"P" = Production File "T" = Test File
CDLHD010	APCD-CDL™ Version Number	Required	~~"3.0.1"~~ "4.0.1"

PER AGENCY REQUEST KDH

~~5.26.~~4 File Trailer

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLTR001	Record Type	Required	
CDLTR002	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLTR004	Data Submitter Name	Required	
CDLTR005	File Type	Required	ME = Member Eligibility MC = Medical Claims PC = Pharmacy Claims DC = Dental Claims PV = Provider File AP = Annual Payments PR = Pharmacy Rebates CF = Capitation File
CDLTR006	Extraction Date	Required	YYYYMMDD
CDLTR007	Control Total of Paid Amount	Situational	Required for claims (MC, PC, and DC) and non-claims (AP, PR, and CF) files. Control total for each file (CDLMC125, CDLPC037, CDLDC060, ~~CDLAP015~~CDLAP016, ~~CDLPR010~~ CDLPR011, ~~CDLMA012~~CDLCF019). Do not code decimal point or provide any punctuation.
CDLTR008	Record Count	Required	Total number of records submitted in the file, excluding header and trailer records.

~~5.3~~6.5 Member Eligibility File

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLME001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLME002	Payer Code	Required	Assigned by HCAI during registration.
CDLME004	Member Insurance / Product Category Code	Required	
CDLME005	Eligibility Year	Required	Must be within the reporting period.
CDLME006	Eligibility Month	Required	Must be within the reporting period.
CDLME007	Insured Group or Policy Number	Required	
CDLME008	Coverage Level Code	Required	
CDLME011	Plan Specific Contract Number	Required	
CDLME012	Subscriber Last Name	Required	
CDLME013	Subscriber First Name	Required	
CDLME017	Individual Relationship Code	Required	
CDLME018	Member Sex	Required	
CDLME019	Member Date of Birth	Required	
CDLME020	Member Last Name	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLME021	Member First Name	Required	
CDLME023	Member Street Address	Required	
CDLME024	Member City Name	Required	
CDLME025	Member State or Province	Required	
CDLME026	Member ZIP Code	Required	
CDLME036	Medical Coverage Under This Plan	Required	
CDLME037	Pharmacy Coverage Under This Plan	Required	
CDLME038	Dental Coverage Under This Plan	Required	
CDLME039	Behavioral Health Coverage Under this Plan	Required	
CDLME040	Primary Insurance Indicator	Required	
CDLME041	Coverage Type	Required	
CDLME042	Plan State	Required	
CDLME043	Market Category Code	Required	
CDLME046	Member PCP ID	Situational	Required when a PCP is assigned: CDLME048 = "1" or "2".

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLME047	NPI of Member's PCP	Situational	Required when a PCP is assigned: CDLME048 = "1" or "2".
CDLME048	PCP Assignment	Required	
CDLME052	HIOS Plan Indicator	Required	
CDLME053	HIOS Plan ID	Situational	Required when CDLME052 = "1".
CDLME054	Metal Tier	Situational	Required when CDLME052 = "1".
CDLME057	Enrolled Through a Public Health Insurance Exchange	Situational	Required when CDLME052 = "1".
CDLME061	Carrier Specific Unique Member ID	Required	
CDLME062	Carrier Specific Unique Subscriber ID	Required	
CDLME075	Member Medicare Beneficiary Identifier	Situational	Required for Medicare beneficiaries.
CDLME076	ACO Identifier	Situational	Required when Member Insurance / Product Category Code (CDLME004) is one of the following values: EP = Exclusive Provider Organization

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
			HM = Health Maintenance Organization (HMO) (commercial only) PR = Preferred Provider Organization (PPO) (commercial only) PS = Point of Service (POS) (commercial only)
CDLME077	ACO Name	Situational	Required when Member Insurance / Product Category Code (CDLME004) is one of the following values: EP = Exclusive Provider Organization HM = Health Maintenance Organization (HMO) (commercial only) PR = Preferred Provider Organization (PPO) (commercial only) PS = Point of Service (POS) (commercial only)
CDLME078	Physician Organization Identifier	Situational	Required when Member Insurance / Product Category Code (CDLME004) is one of the following values: HM = Health Maintenance Organization (HMO) (commercial only)

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
			HN = Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C PS = Point of Service (POS) (commercial only)
CDLME079	Vision Coverage Indicator	Required	
CDLME080	Financial Risk Type	Required	
CDLME899	Record Type	Required	

~~5.4~~6.6 Medical Claims File

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLMC001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLMC002	Payer Code	Required	Assigned by HCAI during registration.
CDLMC004	Member Insurance / Product Category Code	Required	
CDLMC005	Payer Claim Control Number	Required	
CDLMC006	Line Counter	Required	
CDLMC007	Version Number	Required	
CDLMC009	Insured Group or Policy Number	Required	
CDLMC012	Plan Specific Contract Number	Required	
CDLMC013	Subscriber Last Name	Required	
CDLMC014	Subscriber First Name	Required	
CDLMC017	Individual Relationship Code	Required	
CDLMC018	Member Sex	Required	
CDLMC019	Member Date of Birth	Required	
CDLMC020	Member Last Name	Required	
CDLMC021	Member First Name	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLMC022	Member ZIP Code	Required	
CDLMC024	Paid Date	Required	For capitated encounters use processed date.
CDLMC025	Admission Date	Situational	Required for inpatient claims and encounters.
CDLMC026	Admission Hour	Situational	Required for inpatient claims and encounters.
CDLMC027	Admission Type	Situational	Required for inpatient claims and encounters.
CDLMC028	Point of Origin	Situational	Required for institutional claims.
CDLMC029	Discharge Date	Situational	Required for inpatient claims and encounters when Discharge Status (CDLMC031) NOT equal to "30" (Still a patient).
CDLMC030	Discharge Hour	Situational	Required for inpatient claims and encounters when Discharge Status (CDLMC031) NOT equal to "30" (Still a patient).
CDLMC031	Discharge Status	Situational	Required for inpatient claims and encounters.
CDLMC032	Type of Bill – Institutional	Situational	Required for institutional claims.
CDLMC033	Place of Service – Professional	Situational	Required for professional claims.
CDLMC034	Admitting Diagnosis	Situational	Required for inpatient claims.
CDLMC036	ICD Version Indicator	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLMC037	Principal Diagnosis	Required	
CDLMC087	Revenue Code	Situational	Required for institutional claims.
CDLMC088	Procedure Code	Situational	Required for professional and outpatient claims.
CDLMC119	Date of Service – From	Required	
CDLMC120	Date of Service – Thru	Required	
CDLMC121	Service Units/Quantity	Required	Can be zero or negative. A decimal point must be included. Count of services performed: Do NOT hard code this field to a 1 or 0, use the actual data value.
CDLMC122	Unit of Measure	Situational	Required if CDLMC121 is NOT zero.
CDLMC123	Charge Amount	Required	Can be zero or a negative value.
CDLMC125	Plan Paid Amount	Required	Can be zero or a negative value. Capitated claims will be zero.
CDLMC126	Co-Pay Amount	Required	Can be zero or a negative value.
CDLMC127	Coinsurance Amount	Required	Can be zero or a negative value.
CDLMC128	Deductible Amount	Required	Can be zero or a negative value.

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLMC129	Other Insurance Paid Amount	Required	Can be zero or a negative value.
CDLMC131	Allowed Amount	Required	Can be zero or a negative value. For capitated encounters, a Fee-For-Service equivalent amount, including member responsibility amounts, should be included in this field.
CDLMC132	Payment Arrangement Type Indicator	Required	
CDLMC134	Rendering Provider ID	Required	
CDLMC135	Rendering Provider NPI	Situational	Required for non-atypical providers.
CDLMC136	Rendering Provider Entity Type Qualifier	Required	
CDLMC137	In Plan Network Indicator	Required	
CDLMC138	Rendering Provider First Name	Situational	Required when CDLMC136 = "1".
CDLMC140	Rendering Provider Last Name or Organization Name	Required	
CDLMC142	Rendering Provider Specialty	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLMC143	Rendering Provider City Name	Required	
CDLMC144	Rendering Provider State or Province	Required	
CDLMC145	Rendering Provider ZIP Code	Required	
CDLMC147	Billing Provider ID	Required	
CDLMC148	Billing Provider NPI	Required	
CDLMC149	Billing Provider Last Name or Organization Name	Required	
CDLMC156	Type of Claim	Required	
CDLMC157	Claim Status	Required	
CDLMC160	Claim Line Type	Required	
CDLMC161	Carrier Specific Unique Member ID	Required	
CDLMC162	Carrier Specific Unique Subscriber ID	Required	
CDLMC164	Medical Record Number	Situational	Required for Institutional claims and encounters.
CDLMC899	Record Type	Required	

~~5.5~~6.7 Pharmacy Claims File

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPC001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLPC002	Payer Code	Required	Assigned by HCAI during registration.
CDLPC004	Member Insurance/ Product Category code	Required	
CDLPC005	Payer Claim Control Number	Required	
CDLPC006	Line Counter	Required	
CDLPC007	Version Number	Required	
CDLPC009	Insured Group or Policy Number	Required	
CDLPC012	Plan Specific Contract Number	Required	
CDLPC013	Subscriber Last Name	Required	
CDLPC014	Subscriber First Name	Required	
CDLPC017	Individual Relationship Code	Required	
CDLPC018	Member Sex	Required	
CDLPC019	Member Date of Birth	Required	
CDLPC020	Member Last Name	Required	
CDLPC021	Member First Name	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPC022	Member ZIP Code	Required	
CDLPC023	Date Prescription Filled	Required	
CDLPC024	Paid Date	Required	For capitated encounters use processed date.
CDLPC025	Drug Code	Required	Report NDCs only. If CDLPC029 = "Y", report the NDC of the first listed ingredient.
CDLPC026	New Prescription or Refill	Required	
CDLPC027	Generic Drug Indicator	Required	
CDLPC028	Dispensed as Written Code	Required	
CDLPC029	Compound Drug Indicator	Required	
CDLPC030	~~Compound~~ Drug Name or Compound Drug Ingredient List	Situational	~~Required if CDLPC029 = "Y". Use either the compound drug name or a list of NDC codes separated by a semi-colon.~~
CDLPC032	Quantity Dispensed	Required	
CDLPC033	Days' Supply	Required	
CDLPC034	Drug Unit of Measure	Required	
CDLPC035	Prescription Number	Required	
CDLPC036	Charge Amount	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPC037	Plan Paid Amount	Required	Can be zero or a negative value. Capitated encounters will be zero.
CDLPC038	Allowed Amount	Required	Can be zero or a negative value. For capitated encounters, a Fee-For-Service equivalent amount, including member responsibility amounts, should be included in this field.
CDLPC039	Sales Tax Amount	Required	Can be zero or a negative value.
CDLPC040	Ingredient Cost/List Price	Required	Can be zero or a negative value.
CDLPC041	Postage Amount Claimed	Required	Can be zero or a negative value.
CDLPC042	Dispensing Fee	Required	Can be zero or a negative value.
CDLPC043	Co-Pay Amount	Required	Can be zero or a negative value.
CDLPC044	Coinsurance Amount	Required	Can be zero or a negative value.
CDLPC045	Deductible Amount	Required	Can be zero or a negative value.
CDLPC047	Other Insurance Paid Amount	Required	Can be zero or a negative value.
CDLPC048	Member Self- Pay Amount	Required	Can be zero or a negative value.

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPC049	Payment Arrangement Type Flag	Required	
CDLPC050	Prescribing Physician ID	Required	
CDLPC051	Prescribing Physician NPI	Required	
CDLPC052	Prescribing Physician First Name	Required	
CDLPC053	Prescribing Physician Last Name	Required	
CDLPC055	Pharmacy ID	Required	
CDLPC057	Pharmacy NPI	Required	
CDLPC059	Pharmacy Location State	Required	
CDLPC060	Pharmacy ZIP Code	Required	
CDLPC061	Pharmacy Country Code	Required	
CDLPC062	Mail-Order Pharmacy Indicator	Required	
CDLPC064	In Plan Network Indicator	Required	
CDLPC065	Record Status Code	Required	
CDLPC066	Claim Line Type	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPC068	Carrier Specific Unique Member ID	Required	
CDLPC069	Carrier Specific Unique Subscriber ID	Required	
CDLPC071	Pharmacy City	Required	
CDLPC899	Record Type	Required	

~~5.6~~6.8 Dental Claims File

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLDC001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLDC002	Payer Code	Required	Assigned by HCAI during registration.
CDLDC004	Member Insurance / Product Category Code	Required	
CDLDC005	Payer Claim Control Number	Required	
CDLDC006	Line Counter	Required	
CDLDC007	Version Number	Required	
CDLDC009	Insured Group or Policy Number	Required	
CDLDC012	Plan Specific Contract Number	Required	
CDLDC013	Subscriber Last Name	Required	
CDLDC014	Subscriber First Name	Required	
CDLDC017	Individual Relationship Code	Required	
CDLDC018	Member Sex	Required	
CDLDC019	Member Date of Birth	Required	
CDLDC020	Member Last Name	Required	
CDLDC021	Member First Name	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLDC022	Member ZIP Code	Required	
CDLDC023	Paid Date	Required	For capitated encounters use processed date.
CDLDC024	Place of Service - Professional	Required	
CDLDC026	ICD-9/ICD-10 Flag	Situational	Required when CDLDC025 is populated.
CDLDC027	Procedure Code	Required	Valid values can also include CPT and HCPCS.
CDLDC057	Date of Service – From	Required	
CDLDC058	Date of Service – Thru	Required	
CDLDC059	Charge Amount	Required	Can be zero or a negative value.
CDLDC060	Plan Paid Amount	Required	Can be zero or a negative value. Capitated claims will be zero.
CDLDC061	Co-Pay Amount	Required	Can be zero or a negative value.
CDLDC062	Coinsurance Amount	Required	Can be zero or a negative value.
CDLDC063	Deductible Amount	Required	Can be zero or a negative value.
CDLDC064	Allowed Amount	Required	Can be zero or a negative value. For capitated encounters, a Fee-For-Service equivalent amount, including member responsibility amounts,

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
			should be included in this field.
CDLDC065	Payment Arrangement Type Indicator	Required	
CDLDC066	Rendering Provider ID	Required	
CDLDC067	Rendering Provider NPI	Situational	Required for non-atypical providers.
CDLDC068	Rendering Provider Entity Type Qualifier	Required	
CDLDC069	Rendering Provider First Name	Situational	Required when CDLDC068 = "1".
CDLDC071	Rendering Provider Last Name or Organization Name	Required	
CDLDC073	Rendering Provider Specialty	Required	
CDLDC074	Rendering Provider City Name	Required	
CDLDC075	Rendering Provider State or Province	Required	
CDLDC076	Rendering Provider ZIP Code	Required	
CDLDC078	Billing Provider ID	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLDC079	Billing Provider NPI	Required	
CDLDC080	Billing Provider Last Name or Organization Name	Required	
CDLDC083	Claim Status	Required	
CDLDC084	Claim Line Type	Required	
CDLDC085	Carrier Specific Unique Member ID	Required	
CDLDC086	Carrier Specific Unique Subscriber ID	Required	
CDLDC899	Record Type	Required	

~~5.7~~6.9 Provider File

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPV001	Data Submitter Code	Required	Will be assigned by HCAI during registration.
CDLPV002	Payer Code	Required	Will be assigned by HCAI during registration.
CDLPV004	Payer Assigned Provider ID	Required	
CDLPV006	Entity Type Qualifier	Required	
CDLPV007	Provider NPI	Required	
CDLPV010	Provider First Name	Situational	Required when CDLPV006 = "1".
CDLPV012	Provider Last Name or Organization Name	Required	
CDLPV014	Provider Office Street Address	Required	
CDLPV015	Provider Office City	Required	
CDLPV016	Provider Office State	Required	
CDLPV017	Provider Office ZIP Code	Required	
CDLPV019	Provider Country Code	Required	
CDLPV021	Provider Specialty	Required	
CDLPV899	Record Type	Required	

~~5.8~~6.10 Annual Payment File

NCP Data Layout™ APCD -CDL™ Data Element #	Name	HPD Requirements	Notes
CDLAP001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLAP002	Payer Code	Required	Assigned by HCAI during registration.
CDLAP003	Reporting Period Start Date	Required	YYYYMM
CDLAP004	Reporting Period End Date	Required	YYYYMM
CDLAP005	Contract Number	Required	
CDLAP006	Contract Type	Required	~~See NCP Data Layout™ for specific valid values.~~
CDLAP007	Billing Provider ID	Required	
CDLAP008	Billing Provider NPI	Required	Must be a valid NPI.
CDLAP009	Billing Provider Tax ID	Required	Do not include punctuation.
CDLAP010	Billing Provider Last Name or Organization Name	Required	
CDLAP011	Billing Provider First Name	Situational	Required for individual providers.
CDLAP012	Payment Category	Required	~~See NCP Data Layout™ for specific valid values.~~
CDLAP013	Payment Subcategory	Required	~~See NCP Data Layout™ for specific valid values.~~

~~NCP Data Layout™~~APCD -CDL™ Data Element #	Name	HPD Requirements	Notes
CDLAP014	Member Count	Situational	Required when Payment Category (CDLAP012) = 'B', 'C', 'D' or 'Z'.
CDLAP015	Member Months	Situational	Required when Payment Category (CDLAP012) = 'B', 'D' or 'Z', or Payment Subcategory = 'C5' or 'C6'.
CDLAP016	Total Amount Paid/Allowed	Required	Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP017	Total Member Responsibility Amount	Required	Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP018	Total Amount Paid for Primary Care	Required	Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP019	Total Amount Paid for Behavioral Health	Required	Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP899	Record Type	Required	

~~5.9~~6.11 Pharmacy Rebate File

~~NCP Data Layout™~~APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPR001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLPR002	Payer Code	Required	Assigned by HCAI during registration.
CDLPR003	Reporting Period Start Date	Required	YYYYMM
CDLPR004	Reporting Period End Date	Required	YYYYMM
CDLPR005	Drug Code – NDC Product Code	Required	Different from APCD-CDL™ Version 4.0.1, report the 11-digit National Drug Code (NDC) product code. Do not include dashes.
CDLPR006	Drug Manufacturer	Required	
CDLPR007	Drug Name	Required	
CDLPR008	Brand/Generic Indicator	Required	~~See NCP Data Layout™ for specific valid values.~~
CDLPR009	Prescription Count	Required	
CDLPR010	Member Count	Required	Number of members filling a prescription during the reporting period.
CDLPR011	Total Paid Amount	Required	Total amount associated with this specific Drug Code. Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this

~~NCP Data Layout™~~APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
			field is zero, report as "0", not as null. This field may contain a negative value.
CDLPR012	Rebates Received	Required	Total amount of the rebate received for the specified NDC code. Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLPR899	Record Type	Required	

~~5.10~~6.12 Capitation File

~~NCP Data Layout™~~APCD ~~-CDL™~~ Data Element #	Name	HPD Requirements	Notes
CDLCF001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLCF002	Payer Code	Required	Assigned by HCAI during registration.
CDLCF003	Reporting Period Start Date	Required	YYYYMM
CDLCF004	Reporting Period End Date	Required	YYYYMM
CDLCF005	Carrier Specific Unique Member ID	Required	
CDLCF006	Member Last Name	Required	
CDLCF007	Member First Name	Situational	Required when the member has a first name.
CDLCF008	Member Middle Initial	Situational	Required when the member has a middle initial.
CDLCF009	Member Sex	Required	
CDLCF010	Member Date of Birth	Required	
CDLCF011	Member Social Security Number	Situational	Required when available.
CDLCF012	Billing Provider ID	Required	
CDLCF013	Billing Provider NPI	Required	Must be a valid NPI.
CDLCF014	Billing Provider Tax ID	Required	Do not include punctuation.

~~NCP Data Layout™~~APCD ~~-~~CDL™ Data Element #	Name	HPD Requirements	Notes
CDLCF015	Billing Provider Last Name or Organization Name	Required	
CDLCF016	Billing Provider First Name	Situational	Required for individual providers.
CDLCF017	Insurance/Product Category Code	Required	
CDLCF018	Payment Subcategory	Required	~~See NCP Data Layout™ for specific valid values.~~
CDLCF019	Total Paid Amount	Required	Total amount associated with this specific Billing Provider. ~~Round to the nearest dollar (e.g., $1,000.25 converted to 1000).~~ Different from APCD-CDL™ Version 4.0.1, report unrounded amounts (e.g., $1000.25 converted to 100025). This field may contain a negative value.
CDLCF899	Record Type	Required	

ADOPT

APCD All-Payer Claims Database COUNCIL

APCD-CDL™

APCD Common Data Layout

Maintained by APCD Council

VERSION 4.0.1 | RELEASED FEBRUARY 2025

APCD-CDL™

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Acknowledgments

Development of the APCD Common Data Layout (APCD-CDL™) was a collaborative effort of the APCD Council, individuals representing APCDs, APCD contractors and vendors, and data submitters.

The California Department of Health Care Access and Information (HCAI) and Freedman HealthCare developed the Expanded Non-Claims Payment Framework (or Expanded Framework) in consultation with Bailit Health, the author of a Millbank Memorial Fund paper categorizing non-claims-based primary care spending.[1,2] This guidance adds to the Expanded Framework two values for capturing the fee-for-service payments and the member count.

[1] V. Pegany, M. Brandt, N. Tran, M. Valle, and C. Krawcyzk, *A New Standard for Categorizing and Collecting Non-Claims Payment Data,* March 2024, https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/ (accessed March 2024).

[2] E. Taylor, M. Bailit, and D. Kanneganti, *Measuring the Prevalence and Drivers of Non-Claims-Based Care in Commercially Insured Populations*, Milbank Memorial Fund, April 2021, https://www.milbank.org/wp-content/uploads/2021/04/Measuring_Non-Claims_7-1.pdf (accessed March 2024).

Introduction

All-Payer Claims Databases (APCDs) are large-scale databases that systematically collect healthcare payment data from the existing systems created to reimburse healthcare providers. They typically include data derived from medical, pharmacy, and dental claims, other non-claims payments, member eligibility files, and provider (physician and facility) files from private and public payers. APCDs exist as statewide, comprehensive databases managed by a state agency or its designee. APCDs are also created voluntarily for a region or specific stakeholders within a state, usually by nonprofit organizations such as healthcare-related employer business groups or community coalition organizations.

State agencies, employers, providers, consumers, health plans, and other researchers use APCDs for many purposes including, but not limited to:

- Examining healthcare cost, utilization, quality, and outcomes,
- Promoting transparency of healthcare costs,
- Evaluating value-based purchasing,
- Designing wellness programs, and
- Trending and benchmarking.

These use cases inform APCD design. Most are structured to create a single de-identified person identifier across payers to create a longitudinal record of services rendered and all provider reimbursements without duplication.

Purpose

The purpose of the Common Data Layout (CDL) for All-Payer Claims Databases (APCD-CDL™) and its Non-Claims Payment (NCP) Data Layout is to harmonize healthcare payments and member eligibility data collection efforts across states. This unified framework aims to reduce administrative costs and improve the accuracy and efficiency of claims-based and non-claims payment data collection.

State APCD programs determine submission requirements, such as the scope of plans required to submit and which files are required, member inclusion criteria, submission frequency, and due dates, including how much run-out will be allowed and whether to refresh previous years' data.

Technical Specifications

File Content

Each file contains individual data elements, data types, field lengths, and field description/code assignments for collecting claims-based and non-claims payment data from healthcare payers. The submission of the medical, pharmacy, and dental claim is based upon the adjudication date within a given reporting period. All files shall be submitted as separate pipe-delimited files with variable field lengths. Elements with no data should be reported as two pipes together, with no spaces or tab characters padding the field.

Variations from any file layout can cause data processing delays and errors, requiring additional resources to bring non-compliant submissions into the APCD. Therefore, exceptions should only be granted when data submitter compliance is unfeasible. Programs typically only give exceptions for the shortest time possible.

This guidance is intentionally silent on establishing 1) definitions for "primary care" and "behavioral health" and 2) data quality thresholds to allow APCD programs flexibility during testing and implementation. Both will vary across state-designated agencies due to policy and technical capability differences. Care definitions and data quality can also vary by data supplier within a state. For this reason, APCD programs typically set data quality thresholds based on submission testing, expectations setting with data suppliers, and in consultation with other state agencies collecting these data. Exceptions to data quality thresholds might be negotiated and adjusted over time to improve data quality in compliance with submission requirements.

Consistent Identifiers

Providing consistent member, provider, and plan identifiers across all files is critical. A data submitter and any contracted entity acting on their behalf shall ensure that member identifiers for the same individuals are unique and consistent across member eligibility and payment files.

Financial Amounts

Financial amount data elements assume the following:

- The amount paid for each payment record is mutually exclusive.
- The sum of all claim lines for a given claim will equal the total dollar amount of the claim.
- For claims-based payment records (i.e., medical, pharmacy, and dental claims), use an implied decimal when reporting dollar amounts (e.g., $1,000.25 = 100025).
- For non-claims payment records (i.e., annual, pharmacy rebates, and capitation), round or truncate to the nearest dollar and report as an integer (e.g., $1,000.25 = 1000).

A1. Header Record

All file submissions must contain header and trailer records. The header record is the first row of each separate file submission.

HEADER RECORD				
Element #	**Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLHD001	Record Type	char	2	Value=HD
CDLHD002	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLHD003	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLHD004	Data Submitter Name	varchar	75	Name of data submitter.
CDLHD005	File Type	char	2	ME=Member Eligibility MC=Medical Claims PC=Pharmacy Claims DC=Dental Claims PV=Provider File AP=Annual Payments PR=Pharmacy Rebates PV=Provider File
CDLHD006	Period Beginning Date	date	6	YYYYMM. Beginning of period covered for Eligibility. Beginning of paid/adjudicated period for Claims. Beginning of period for Provider file updates.
CDLHD007	Period Ending Date	date	6	YYYYMM. End of period covered for Eligibility. End of paid/adjudicated period for Claims. End of period for Provider file updates.
CDLHD008	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.

HEADER RECORD				
CDLHD009	Comments	varchar	50	Comments.
CDLHD010	APCD-CDL™ Version Number	varchar	8	The version of the APCD-CDL™ used to produce this file (e.g., 3.0.1).

A2. Trailer Record

All file submissions must contain header and trailer records. The trailer record is the last row of each separate file submission.

TRAILER RECORD				
Element #	**Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLTR001	Record Type	char	2	Value=TR
CDLTR002	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLTR003	Payer Code	varchar	8	APCD-assigned identifier of insurer/underwriter in the case of premiums- based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLTR004	Data Submitter Name	varchar	75	Name of data submitter.
CDLTR005	File Type	char	2	ME=Member Eligibility MC=Medical Claims PC=Pharmacy Claims DC=Dental Claims PV=Provider File AP=Annual Payments PR=Pharmacy Rebates PV=Provider File

TRAILER RECORD				
CDLTR006	Extraction Date	date	8	YYYYMMDD; Date file was created.
CDLTR007	Control Total of Paid Amount	int	12	Provide total paid dollars submitted in the file. Control total for each file (CDLMC125, CDLPC037, CDLDC060, CDLAP016, CDLPR011, CDLCF019). Eligibility and provider file blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).
CDLTR008	Record Count	int	10	Total number of records submitted in the file, excluding header and trailer records.

B. Member Eligibility File (ME)

A member eligibility file is a data file composed of demographic information for each member eligible for medical, pharmacy, and dental benefits for one or more days of coverage at any time during the reporting period. Data suppliers must provide a data set that contains information on every covered plan member, regardless of whether the member utilized services during the reporting period. One record per member, per month, per plan, is required. For example, if a member is covered as a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has two contract numbers for two different coverage types, two member eligibility records must be submitted. However, if a member has more than one record due to an address or other change, send only the most current record. References to the ASC X12 270/271 and 834 implementation guides are provided in the tables below.

MEMBER ELIGIBILITY FILE

Element #	Element Name	Type	Max Length	Description/ Codes/ Sources	ASC X12N 271 and 834 References
CDLME001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code used in the Payer Code field.	N/A
CDLME002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLME003	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER)	271/2100A/NM109 where NM108 = XV

MEMBER ELIGIBILITY FILE					
CDLME004	Member Insurance/ Product Category code	char	2	See Appendix J: Insurance/Product Category for codes. Use the most granular choice available.	Subscriber: 271/2110CA/EB04* Member: 271/2110DA/EB04* *With additional values outlined in Appendix J
CDLME005	Eligibility Year	int	4	The year for which eligibility is reported in this submission file. YYYY.	N/A
CDLME006	Eligibility Month	char	2	The month for which eligibility is reported in this submission file is expressed numerically from 01 to 12. One record per member, per month, per plan is required.	N/A
CDLME007	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. ME006 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, then report a value of "IND". If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	Subscriber: 271/2100CA/REF02 where REF01=1L, IG, 6P Member: 271/2100DA/REF02 where REF01=1L, IG, 6P

MEMBER ELIGIBILITY FILE					
CDLME008	Coverage Level Code	char	3	Benefit coverage level selected: CHD=Children Only; DEP=Dependents Only; ECH=Subscriber and Children/Dependents; EMP=Subscriber Only; ESP=Subscriber and Spouse/Life Partner; FAM=Family; SPC=Spouse/Life Partner and Children/Dependents; SPO=Spouse/Life Partner Only.	Subscriber: 271/2110CA/EB02 Member: 271/2110DA/EB02
CDLME009	Medicaid AID Category	varchar	10	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A
CDLME010	Subscriber Social Security Number	char	9	Subscriber's Social Security Number. Do not include dashes. Leave blank if not collected.	271/2100CA/REF02 where REF01 = SY
CDLME011	Plan Specific Contract Number	varchar	80	Plan assigned contract number. If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid eligibility record, provide Medicaid ID.	Subscriber: 271/2100CA/NM109 where NM108=MI
CDLME012	Subscriber Last Name	varchar	60	The subscriber's last name.	271/2100CA/NM103
CDLME013	Subscriber First Name	varchar	35	The subscriber's first name.	271/2100CA/NM104
CDLME014	Subscriber Middle Initial	char	1	The subscriber's middle initial.	271/2100CA/NM105
CDLME015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber use subscriber sequence number.	N/A
CDLME016	Member Social Security Number	char	9	Member's Social Security Number. Do not include dashes. Leave blank if not collected.	271/2100DA/REF02 where REF01=SY

MEMBER ELIGIBILITY FILE					
CDLME017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship Code is maintained by ANSI ASC X12. See Appendix L: External Code Source, Accredited Standards Committee.	Subscriber: 271/2100CA/INS02 Member: 271/2100DA/INS02 where INS01=N
CDLME018	Member Sex	char	1	Sex of the member. M=Male; F=Female; U=UNKNOWN. Member sex represents biological or administrative sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values). If the member is the subscriber, report the subscriber's sex.	Subscriber: 271/2100CA/DMG03 Member: 271/2100DA/DMG03
CDLME019	Member Date of Birth	date	8	Date of birth of the member. If the member is the subscriber, report the subscriber's date of birth. YYYYMMDD.	Subscriber: 271/2100CA/DMG02 Member: 271/2100DA/DMG02
CDLME020	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	Subscriber: 271/2100CA/NM103 Member: 271/2100DA/NM103

MEMBER ELIGIBILITY FILE					
CDLME021	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	Subscriber: 271/2100CA/NM104 Member: 271/2100DA/NM104
CDLME022	Member Middle Initial	char	1	The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.	Subscriber: 271/2100CA/NM105 Member: 271/2100DA/NM105
CDLME023	Member Street Address	varchar	55	First line of street address of member's residence. If the member is the subscriber, report the street address of the subscriber's residence.	Subscriber: 271/2100CA/N301 Member: 271/2100DA/N301
CDLME024	Member City Name	varchar	30	City location of member's residence. If the member is the subscriber, report the city location of the subscriber's residence.	Subscriber: 271/2100CA/N401 Member: 271/2100DA/N401
CDLME025	Member State or Province	char	2	State or province of member's residence. If the member is the subscriber, report the state or province of the subscriber's residence. State or Province codes are maintained by the US Postal Service. See Appendix L: External Code Sources, United States Postal Service.	Subscriber: 271/2100CA/N402 Member: 271/2100DA/N402
CDLME026	Member ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the member's residence. If the member is the subscriber, report the Zip Code of the subscriber's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix L: External Code Sources.	Subscriber: 271/2100CA/N403 Member: 271/2100DA/N403

MEMBER ELIGIBILITY FILE					
CDLME027	Member FIPS County Code	char	5	Report the FIPS county code based on the member's residential address. If the member is the subscriber, report the FIPS county code of the subscriber's residence. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. If member lives outside US, leave blank. See Appendix L: External Code Source, United States Census Bureau.	N/A
CDLME028	Member Country Code	char	2	Country of member's residence. If the member is the subscriber, report the country code of the subscriber's residence. Report two-digit code. Code US for United States. See Appendix L: External Code Source, United States Postal Service.	N/A
CDLME029	Race 1	varchar	21	Report the Member-identified race. If the member is the subscriber, report the subscriber's race. The code value "UN" (Unknown/not specified) should be used ONLY when Member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix L: External Code Sources, Centers for Disease Control and Prevention. Use Concept Code unless otherwise specified.	N/A

MEMBER ELIGIBILITY FILE					
CDLME030	Race 2	varchar	21	Report the Member-identified race. If the member is the subscriber, report the subscriber's race. The code value "UN" (Unknown/not specified) should be used ONLY when Member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix L: External Code Sources, Centers for Disease Control and Prevention. Use Concept Code unless otherwise specified.	N/A
CDLME031	Race 3	varchar	21	Report the Member-identified race. If the member is the subscriber, report the subscriber's race. The code value "UN" (Unknown/not specified) should be used ONLY when Member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix L: External Code Sources, Centers for Disease Control and Prevention. Use Concept Code unless otherwise specified.	N/A
CDLME032	Hispanic Indicator	char	1	Report the value that defines the element. The code value "U" for unknown, should be used ONLY when the member/subscriber answers unknown or refuses to answer. Report only collected data. If not available leave blank. Y=Member is Hispanic/Latino/Spanish; N=Member is not Hispanic/Latino/Spanish; U=Unknown/not specified.	N/A

MEMBER ELIGIBILITY FILE					
CDLME033	Ethnicity 1	varchar	21	Report the self-reported ethnicity using the six-character Concept Code that best describes the information obtained from the Member/Subscriber. For example, the Concept Code for an ethnicity value of Costa Rican is "2156-8", and the Concept Code for an ethnicity value of Hispanic is "2135-2". The value "UNKNOW" should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data and leave blank if not available. See Appendix L: External Code Sources, Centers for Disease Control and Prevention. Use Concept Code unless otherwise specified.	N/A
CDLME034	Ethnicity 2	varchar	21	Report the self-reported ethnicity using the six-character Concept Code that best describes the information obtained from the Member/Subscriber. For example, the Concept Code for an ethnicity value of Costa Rican is "2156-8", and the Concept Code for an ethnicity value of Hispanic is "2135-2". The value "UNKNOW" should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data and leave blank if not available. See Appendix L: External Code Sources, Centers for Disease Control and Prevention. Use Concept Code unless otherwise specified.	N/A

MEMBER ELIGIBILITY FILE					
CDLME035	Other Ethnicity	varchar	21	Report the self-reported ethnicity using the six-character Concept Code that best describes the information obtained from the Member/Subscriber. For example, the Concept Code for an ethnicity value of Costa Rican is "2156-8", and the Concept Code for an ethnicity value of Hispanic is "2135-2". The value "UNKNOW" should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data and leave blank if not available. See Appendix L: External Code Sources, Centers for Disease Control and Prevention. Use Concept Code unless otherwise specified.	N/A
CDLME036	Medical Coverage Under This Plan	char	1	Use this field to indicate whether medical coverage is part of this member's plan (Note: medical coverage may be bundled with other types of coverage) Medical coverage includes any type of coverage besides prescription drug. Y=Yes; N=No.	N/A
CDLME037	Pharmacy Coverage Under This Plan	char	1	Use this field to indicate whether pharmacy coverage is part of this member's plan (Note: pharmacy coverage may include prescription drugs, supplies and DME; and may be bundled with other types of coverage) Y=Yes; N=No.	N/A

MEMBER ELIGIBILITY FILE					
CDLME038	Dental Coverage Under This Plan	char	1	Use this field to indicate whether dental coverage is part of this member's plan (Note: dental coverage may be bundled with other types of coverage) Y=Yes; N=No.	N/A
CDLME039	Behavioral Health Coverage Under this Plan	char	1	Use this field to indicate whether behavioral health coverage is part of this member's plan (Note: behavioral health coverage may be bundled with other types of coverage). Valid codes include: Y=Yes; N=No.	N/A
CDLME040	Primary Insurance Indicator	char	1	Use this field to report whether the policy for this eligibility record is the primary insurance for the member. Y=Yes, primary insurance; N=No, this is not the member's primary insurance.	N/A

MEMBER ELIGIBILITY FILE					
CDLME041	Coverage Type	char	3	This field identifies which entity holds the risk. ASW=Self-funded plans administered by a TPA, where the employer has purchased stop-loss, or group excess insurance coverage; ASO=Self- funded plans administered by a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage; STN=Short-term, non-renewable health insurance (e.g., COBRA); UND=Plans underwritten by the insurer (i.e., fully insured group and individual policies); MEW=Associations/Trusts and Multiple Employer Welfare Arrangements; OTH=Any other plan (e.g., student health plan). States may require prior approval to use OTH.	N/A
CDLME042	Plan State	char	2	State in which the plan is sold/sitused. State or Province codes are maintained by the US Postal Service. See Appendix L: External Code Sources, United States Postal Service.	N/A
CDLME043	Market Category Code	varchar	4	Code for identifying market category. See Appendix K: Market Category Codes which defines the market category by size and or association to which the policy is directly sold and issued. Report subscribers (not employees).	N/A
CDLME044	Special Coverage	varchar	6	Reserved for specific state coverage. 0=Not applicable; XXXXXX=Specific state coverage.	N/A

MEMBER ELIGIBILITY FILE					
CDLME045	Group Name	varchar	60	Name of the group which is covering the member (the name established in the payer's system and not the full legal name). If the member is a group of one, or covered by an individual non-group, Medicaid, or Medicare policy, then report a value of "IND".	N/A
CDLME046	Member PCP ID	varchar	35	Unique code identified for the Primary Care Provider (PCP). If the member is the subscriber, report the subscriber's PCP. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank.	N/A
CDLME047	NPI of Member's PCP	char	10	NPI of the member's Primary Care Provider. If the member is the subscriber, report the NPI of the subscriber's PCP. If not applicable, leave blank.	N/A
CDLME048	PCP Assignment	char	1	1=PCP in CDLME046 was selected by the member; 2=PCP in CDLME046 was attributed by the health plan; 3=PCP is not selected, and no services rendered; 4=PCP is not assigned/unknown.	N/A
CDLME049	Member PCP Effective Date	date	8	Primary Care Provider Effective Date with member if CDLME048=1 or 2 (PCP Assignment). If the member is the subscriber, report the subscriber's PCP effective date. Report the date in YYYYMMDD format. If not applicable, leave blank.	N/A

MEMBER ELIGIBILITY FILE					
CDLME050	Plan Effective Date	date	8	YYYYMMDD. Effective date of coverage; Date eligibility started for this member under this plan type. The purpose of this data element is to maintain an eligibility span for each member.	N/A
CDLME051	Plan Term Date	date	8	YYYYMMDD. Last continuous day of coverage (date eligibility ended) for this member under this plan. The purpose of this data element is to maintain an eligibility span for each member. For open contracts, leave blank.	N/A
CDLME052	HIOS Plan indicator	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Is the member enrolled in a Health Insurance Oversight System plan? 1=Yes; 2=No; 3=Unknown/not applicable.	N/A
CDLME053	HIOS Plan ID	varchar	16	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Required for qualified health plans (QHPs) as defined in the Patient Protection and Affordable Care Act (ACA). If CDLME052 is NOT=1, leave blank. The HIOS Plan ID (Standard Component) includes a five-digit issuer ID, two-character state ID, 3-digit product number, four-digit standard component number and two-digit variant component ID. This field may not be available for all market segments. If not applicable, leave blank.	N/A

MEMBER ELIGIBILITY FILE					
CDLME054	Metal Tier	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements: 0=Not a QHP or catastrophic plan; 1=Catastrophic; 2=Bronze; 3=Silver; 4=Gold; 5=Platinum. If not applicable, leave blank.	N/A
CDLME055	Medical Home Indicator	int	1	Use this field to report whether the member had a medical home on record for this coverage period. If not stored in payer system, use code '3'. Valid codes include: 1=Yes; 2=No; 3=Unknown/not applicable.	N/A
CDLME056	Payer assigned ID for Medical Home	varchar	35	Unique code identified for the Medical Home (as assigned by the reporting entity). Payer assigned ID for the Medical Home is for the Medical Home to which the member belongs. Payer assigned ID for the Medical Home is the identifier used by the payer for internal identification purposes and does not routinely change. Must correspond to a Payer Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank.	N/A

MEMBER ELIGIBILITY FILE					
CDLME057	Enrolled Through a Public Health Insurance Exchange	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Use this field to report whether the policy for this eligibility record was enrolled through a Public Health Insurance Exchange. Valid codes include: 1=Yes; 2=No; 3=Unknown/ not applicable.	N/A
CDLME058	Employer Tax ID	char	9	Subscriber's employer EIN or SSN – do not include dashes or provide any punctuation. If coverage not purchased through or enrolled by an employer, leave blank. If not received leave blank.	N/A
CDLME059	Employment Status	char	1	Report the code that defines the employment status of the member/subscriber: A=Active; I=Involuntary Leave; P=Pending; R=Retiree; Z=Unemployed; U=Unknown.	N/A
CDLME060	Employer ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the employer (as reported in CDLME058) When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. If coverage not purchased through or enrolled by an employer, leave blank. ZIP Codes are maintained by the US Postal Service. See Appendix L: External Code Source.	N/A

MEMBER ELIGIBILITY FILE					
CDLME061	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLME062	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLME063	NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. Leave blank if entity does not have a NAIC Code. See Appendix L: External Code Source; NAIC codes are maintained by the National Association of Insurance Commissioners.	N/A
CDLME064	High Deductible Plan Indicator	char	1	High deductible plan as defined by the IRS at start of plan year. Valid codes include: Y=Yes; N=No. If not applicable, leave blank.	N/A

MEMBER ELIGIBILITY FILE					
CDLME065	Total Monthly Premium Amount	int	12	For fully-insured premiums, report the monthly fee paid by a subscriber and/or employer for health insurance coverage for a given number of members (e.g. individual, individual plus one, family), prior to any medical loss ratio rebate payments, but inclusive of any fees paid to a third party (e.g., exchange fees, reinsurance). Report the total monthly premium at the Subscriber level only. Do not report on member lines. Report 0 if no premium is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLME066	Actuarial Value	dec	6, 4	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Report value as calculated in the most recent version of the HHS Actuarial Value Calculator. Include decimal point with reported value. Format to be used is 0.0000. For example, an AV of 88.27689% should be reported as 0.8828. Required as of January 1, 2014, for small group and non-group (individual) plans sold inside or outside the Exchange. If not applicable, leave blank. See Appendix L: External Code Source, Centers for Medicaid and Medicare Services.	N/A

MEMBER ELIGIBILITY FILE					
CDLME067	Grand-fathered Plan Indicator	char	1	Indicates if a plan qualifies as a "Grandfathered" or "Transitional Plan" under the Affordable Care Act (ACA). Please see definition for "grandfathered" and "transitional" in HHS rules 45-CFR-147.140: https://www.federalregister.gov/select-citation/2013/06/03/45-CFR-147 The values of the indicator are as follows: 1=Grandfathered; 2=Non-Grandfathered; 3=Transitional; 4=Not Applicable.	N/A

MEMBER ELIGIBILITY FILE					
CDLME068	Cost-Sharing Reduction Indicator	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Indicates cost-sharing reduction under the Affordable Care Act (ACA). This is a person- level indicator in which enrollees who qualify for cost-sharing reduction are assigned cost- sharing indicator values of 1-8. Non-Cost-Sharing recipients are assigned a cost-sharing indicator value of zero. Valid codes include: 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 (Qualified Health Plan); 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.	N/A

MEMBER ELIGIBILITY FILE					
CDLME069	Administrative Service Fees	int	12	Administrative Service Fees (ASFs): Average monthly fee paid by an employer to cover its self- insured health plan administration, excluding any stop-loss premiums, and divided by the number of members under administration. Administrator services for these fees may vary, including plan design and network access, claims adjudication and administration, and/or population health management. Primary reporting goal will be to monitor self-insured coverage costs over time, using ASFs as one component of a "premium-equivalent." Report 0 if no fee is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Required when CDLME041=ASW or ASO.	N/A

MEMBER ELIGIBILITY FILE					
CDLME070	Tiered Network	char	1	Tiered Network: Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality and/or the cost of care provided. Tiers are not considered separate networks, but rather sub-segments of a payer's HMO or PPO network. A tiered network is different than a plan only splitting benefits by in- network vs. out-of-network; a tiered network will have varying degrees of payments of in-network providers. Report the code that defines the tier network of the member/subscriber's plan: 0=Limited Network; 1=Single Tier-Not tiered; 2=Two Tier; 3=Three Tier; 4=Four Tier; 5=Other.	N/A
CDLME071	Member Income Frequency Code	char	1	Report the frequency for the member income as reported at enrollment: 1=Weekly; 2=Bi-Weekly; 3=Semi-Monthly; 4=Monthly; 6=Daily; 7=Annually; 8=Two calendar months; 9=Lump sum separation allowance. If the member is the subscriber, report the subscriber's income frequency.	834/2100A/ICM01

MEMBER ELIGIBILITY FILE					
CDLME072	Member Income Monetary Amount	int	12	Member's annual income as reported during enrollment. If the member is the subscriber, report the subscriber's income. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	834/2100A/ICM02
CDLME073	Member Primary Language	char	3	Report the primary language of the member. If the member is the subscriber, report the subscriber's primary language. See Appendix L: External Code Source, ISO 639 Language Codes	834/2100/LUI02
CDLME074	Un-assigned	char	1	Reserved for future use. Elements will only be added with approval from the APCD-CDL™ Maintenance and Change Committee.	N/A
CDLME075	Member Medicare Beneficiary Identifier	varchar	11	Member's Medicare Beneficiary Identifier. Required only for Medicare Supplemental/Companion.	271/2100CA/NM109 where NM108 = MI
CDLME076	ACO Identifier	varchar	30	APCD agencies will provide guidance as to what values are to be reported in this field	N/A
CDLME077	ACO Name	varchar	60	APCD agencies will provide guidance as to what values are to be reported in this field	N/A
CDLME078	Physician Organization Identifier	varchar	30	For managed care members assigned a PCP, the identifier of the physician group or provider organization or to which the PCP belongs. APCD agencies may provide state-specific guidance on what IDs to use	N/A

MEMBER ELIGIBILITY FILE					
CDLME079	Vision Coverage Indicator	char	1	Use this field to indicate whether vision coverage is part of this member's plan. (Note: vision coverage may be bundled with other types of coverage.) Y=Yes; N=No.	N/A
CDLME080	Financial Risk Type	int	1	Indicate the type of capitated financial risk contract(s) for a member to the member eligibility file, including the following values: 1=Professional capitation only (no facility capitation); 2=Facility capitation only (no professional capitation); 3=Professional and facility capitation (plan has separate capitation contracts for professional services (with PO) and facility costs (generally with hospital)); 4=Global capitation (single contract with PO for both professional and facility); 5=No capitation, fee-for-service only; 6=Other.	N/A

MEMBER ELIGIBILITY FILE					
CDLME081	Member Gender Identity	varchar	4	A person's internal sense of being a man, woman, both, or neither. 1=Male; 2=Female; 3=Female-to-Male (FTM)/Transgender Male/Trans Man; 4=Male-to-Female (MTF)/Transgender Female/Trans Woman; 5=Genderqueer, neither exclusively male nor female; 6=Additional gender category or other; 7=Choose not to disclose. If the member is the subscriber, report the subscriber's gender identity.	N/A
CDLME082	Member Sexual Orientation	varchar	4	A person's identification of their emotional, romantic, sexual, or affectional attraction to another person. 1=Lesbian, gay, or homosexual; 2=Straight or heterosexual; 3=Bisexual; 4=Something else; 5=Don't know; 6=Choose not to disclose. If the member is the subscriber, report the subscriber's sexual orientation.	N/A

MEMBER ELIGIBILITY FILE					
CDLME083	Member Street Address 2	varchar	55	Second line of street address of member's residence. If the member is the subscriber, report the street address of the subscriber's residence.	Subscriber: 271/2100CA/N302 Member: 271/2100DA/N302
CDLMEXXX	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLME899	Record Type	char	2	Value=ME	N/A

C. Medical Claims File (MC)

This file accommodates data on service-level claims and remittance information for medical services, including member demographics, provider details, payment amounts, clinical diagnosis codes, and procedure codes. Many data element descriptions refer to "inpatient" claims; please refer to the National Uniform Billing Committee for the definition of "inpatient." References to the relevant ASC X12 transactions are provided.

MEDICAL CLAIMS FILE					
Element #	**Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLMC002).	N/A
CDLMC002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLMC003	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	837/2010AC/NM109 where NM108 = XV
CDLMC004	Member Insurance/ Product Category Code	char	2	See Appendix J: Insurance Type/Product Category for codes. Use the most granular choice available. Code reported must align with the member's enrollment product (CDLME004) during the time of service.	271/2110DA/EB04* *With additional values outlined in Appendix J

MEDICAL CLAIMS FILE					
CDLMC005	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLMC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	837/2300/REF02 where REF01=F8
CDLMC006	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	837/2400/LX01
CDLMC007	Version Number	int	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, Cross Reference Claims ID (CDLMC008) is to be utilized.	N/A
CDLMC008	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLMC005). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLMC007) is not used.	N/A

MEDICAL CLAIMS FILE					
CDLMC009	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLME007 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, then report a value of "IND". If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	837/2320A/SBR03
CDLMC010	Medicaid AID Category	varchar	10	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A
CDLMC011	Subscriber Social Security Number	char	9	Subscriber's Social Security Number. Do not include dashes. Leave blank if not collected.	837/2010BA/REF02 where REF01 = SY
CDLMC012	Plan Specific Contract Number	varchar	80	Plan assigned contract number. Leave blank if Plan Specific Contract Number is the subscriber's Social Security Number. If this is a Medicaid claim, provide Medicaid ID.	Subscriber: 837/2010BA/NM109 where NM108 = MI Member/Patient: 837/2010CA/NM109 where NM108 = MI
CDLMC013	Subscriber Last Name	varchar	60	The subscriber's last name.	837/2010BA/NM103
CDLMC014	Subscriber First Name	varchar	35	The subscriber's first name.	837/2010BA/NM104
CDLMC015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.	N/A

MEDICAL CLAIMS FILE					
CDLMC016	Member Social Security Number	char	9	Member's Social Security Number. If the member is the subscriber, report the subscriber's SSN. Do not include dashes. Leave blank if not collected.	Subscriber: 837/2010BA/REF102 where REF01 = SY Member/Patient: 837/2010CA/REF102 where REF01 = SY
CDLMC017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes are maintained by ANSI ASC X12. See Appendix L: External Code Source, see Accredited Standards Committee.	Subscriber: 837/2000B/SBR02 Member/Patient: 837/2000C/PAT01
CDLMC018	Member Sex	char	1	Sex of the Member. M=Male; F=Female; U=Unknown. Member sex represents biological or administrative sex. If the member is the subscriber, report the subscriber's sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have regarding physical or legal sex (e.g., administrative sex as categorized by X12 values).	Subscriber: 837/2010BA/DMG03 Member/Patient: 837/2010CA/DMG03
CDLMC019	Member Date of Birth	date	8	YYYYMMDD; Date of birth of member. If the member is the subscriber, report the subscriber's date of birth.	Subscriber: 837/2010BA/DMG02 Member/Patient: 837/2010CA/DMG02

MEDICAL CLAIMS FILE					
CDLMC020	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	Subscriber: 837/2010BA/NM103 Member/Patient: 837/2010CA/NM103
CDLMC021	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	Subscriber: 837/2010BA/NM104 Member/Patient: 837/2010CA/NM104
CDLMC022	Member ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the member's residence. If the member is the subscriber, report the Zip Code of the subscriber's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix L: External Code Sources.	Subscriber: 837/2010BA/N403 Member/Patient: 837/2010CA/N403
CDLMC023	Patient Control Number	varchar	20	Patient secondary identification. Patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services.	Subscriber: 837/2010CA/REF02 Member/Patient: 837/2010CA/REF02
CDLMC024	Paid Date	date	8	YYYYMMDD. Paid date of the claim line. Report the date that appears on the: check, and/or remit, and/or explanation of benefits, and corresponds to any and all types of payment in YYYYMMDD Format. If paid/adjudicated date is not available, use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here.	837/2330A/DTP03 where DTP01=573

MEDICAL CLAIMS FILE					
CDLMC025	Admission Date	date	8	YYYYMMDD. Required for all inpatient claims, this is the date of admission.	837/2300/DTP03 where DTP01=435 (I)
CDLMC026	Admission Hour	char	4	HHMM. (Military time) The hour during which the patient was admitted for inpatient care.	837/2300/DTP03 where DTP01=435 and DTP02=DT (I)
CDLMC027	Admission Type	char	1	Required for all inpatient claims. Valid codes are: 1=Emergency; 2=Urgent; 3=Elective; 4=Newborn; 5=Trauma Center; 9=Information not available. For professional claims, leave blank. Admission Type codes are maintained by NUBC. See Appendix L: External Code Source, National Uniform Billing Committee.	837/2300/CL101 (I)
CDLMC028	Point of Origin	char	1	A code indicating the point of patient origin for this admission or visit. Required for all institutional claims. Admission Type codes are maintained by NUBC. See Appendix L: External Code Source, National Uniform Billing Committee.	837/2300/CL102 (I)
CDLMC029	Discharge Date	date	8	YYYYMMDD. Date patient discharged. Required for all inpatient claims.	837/2300/HI01-03 where HI01-02 = 42
CDLMC030	Discharge Hour	char	4	HHMM (Military time). The hour during which the patient was discharged from inpatient care. For professional claims, leave blank.	837/2300/DTP03 where DTP01=096 and DTP02=TM (I)

MEDICAL CLAIMS FILE					
CDLMC031	Discharge Status	char	2	Required for all institutional claims. Discharge Status codes are maintained by NUBC. For professional claims, leave blank. See Appendix L: External Code Source, National Uniform Billing Committee.	837/2300/CL103 (I)
CDLMC032	Type of Bill – Institutional	char	3	Required for institutional claims. Not to be used for professional claims. As defined by the National Uniform Billing Committee. Do not include the leading zero. Type of Bill codes are maintained by NUBC. See Appendix L: External Code Source, National Uniform Billing Committee.	837/2300/CLM05-02 & CLM05-03 (I)
CDLMC033	Place of Service – Professional	char	2	Required for professional claims. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix L: External Code Source, Center for Medicaid and Medicare Services.	837/2300/CLM05-01 (P)
CDLMC034	Admitting Diagnosis	varchar	7	The ICD code describing the patient's diagnosis at the time of admission. Required on all inpatient admission claims and encounters. Codes found in ICD-9-CM or ICD -10-CM. Do not code decimal point. See Appendix L: External Code Source, World Health Organization.	837/2300/HI01-02 (I)

MEDICAL CLAIMS FILE					
CDLMC035	First External Cause Code	varchar	7	The ICD diagnosis codes pertaining to environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. As submitted by provider in the first external cause field- if not submitted by the provider or captured by the carrier leave blank. Codes found in ICD-9-CM or ICD -10-CM. Do not code decimal point. See Appendix L: External Code Source, World Health Organization.	837/2300/HI01-02 where HI01-01=ABJ (ICD- 10)
CDLMC036	ICD Version Indicator	char	1	The purpose of this field is to identify which code set is being utilized. 9=This claim contains ICD-9- CM codes. 0=This claim contains ICD-10-CM codes.	N/A
CDLMC037	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. Cannot include codes V00-Y99. See Appendix L: External Code Source.	837/2300/HI01-02 where HI01-01=ABK (ICD-10)
CDLMC038	Other Diagnosis – 1	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI01-02 where HI01-01=ABF (ICD-10)
CDLMC039	Other Diagnosis – 2	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI02-02 where HI02-01=ABF (ICD-10)
CDLMC040	Other Diagnosis – 3	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI03-02 where HI03-01=ABF (ICD-10)

MEDICAL CLAIMS FILE					
CDLMC041	Other Diagnosis – 4	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI04-02 where HI04-1=ABF (ICD-10)
CDLMC042	Other Diagnosis – 5	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI05-02 where HI05-01=ABF (ICD-10)
CDLMC043	Other Diagnosis – 6	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI06-02 where HI06-01=ABF (ICD-10)
CDLMC044	Other Diagnosis – 7	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI07-02 where HI07-01=ABF (ICD-10)
CDLMC045	Other Diagnosis – 8	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI08-02 where HI08-1=ABF (ICD-10)
CDLMC046	Other Diagnosis – 9	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI09-02 where HI09-01=ABF (ICD-10)

MEDICAL CLAIMS FILE					
CDLMC047	Other Diagnosis – 10	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI10-02 where HI10-01=ABF (ICD-10)
CDLMC048	Other Diagnosis – 11	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI11-02 where HI11-01=ABF (ICD-10)
CDLMC049	Other Diagnosis – 12	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI12-02 where HI12-01=ABF (ICD-10)
CDLMC050	Other Diagnosis – 13	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI13-02 where HI13-01=ABF (ICD-10)
CDLMC051	Other Diagnosis – 14	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI14-02 where HI14-01=ABF (ICD-10)
CDLMC052	Other Diagnosis – 15	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI15-02 where HI15-01=ABF (ICD-10)

MEDICAL CLAIMS FILE					
CDLMC053	Other Diagnosis – 16	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI16-02 where HI16-01=ABF (ICD-10)
CDLMC054	Other Diagnosis – 17	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI17-02 where HI17-01=ABF (ICD-10)
CDLMC055	Other Diagnosis – 18	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI18-02 where HI18-01=ABF (ICD-10)
CDLMC056	Other Diagnosis – 19	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI19-02 where HI19-01=ABF (ICD-10)
CDLMC057	Other Diagnosis – 20	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI20-02 where HI20-01 =ABF (ICD-10)
CDLMC058	Other Diagnosis – 21	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI21-02 where HI21-01=ABF (ICD-10)

MEDICAL CLAIMS FILE					
CDLMC059	Other Diagnosis – 22	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI22-02 where HI22-01=ABF (ICD-10)
CDLMC060	Other Diagnosis – 23	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI23-02 where HI23-01=ABF (ICD-10)
CDLMC061	Other Diagnosis – 24	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI24-02 where HI24-01=ABF (ICD-10)

MEDICAL CLAIMS FILE					
CDLMC062	Present on Admission Code -01	char	1	Present on Admission Indicator Principal Diagnosis For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABK/HI01-09

MEDICAL CLAIMS FILE					
CDLMC063	Present on Admission Code -02	char	1	POA Indicator for Other Diagnosis – 1. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI01-09

MEDICAL CLAIMS FILE					
CDLMC064	Present on Admission Code -03	char	1	POA Indicator for Other Diagnosis – 2. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI02-09

MEDICAL CLAIMS FILE					
CDLMC065	Present on Admission Code -04	char	1	POA Indicator for Other Diagnosis – 3. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI03-09

MEDICAL CLAIMS FILE					
CDLMC066	Present on Admission Code -05	char	1	POA Indicator for Other Diagnosis – 4. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI04-09

MEDICAL CLAIMS FILE					
CDLMC067	Present on Admission Code -06	char	1	POA Indicator for Other Diagnosis – 5. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI05-09

MEDICAL CLAIMS FILE					
CDLMC068	Present on Admission Code -07	char	1	POA Indicator for Other Diagnosis – 6. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI06-09

MEDICAL CLAIMS FILE					
CDLMC069	Present on Admission Code -08	char	1	POA Indicator for Other Diagnosis – 7. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI07-09

MEDICAL CLAIMS FILE					
CDLMC070	Present on Admission Code -09	char	1	POA Indicator for Other Diagnosis – 8. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI08-09

MEDICAL CLAIMS FILE					
CDLMC071	Present on Admission Code -10	char	1	POA Indicator for Other Diagnosis – 9. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI09-09

MEDICAL CLAIMS FILE					
CDLMC072	Present on Admission Code -11	char	1	POA Indicator for Other Diagnosis – 10. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI10-09

MEDICAL CLAIMS FILE					
CDLMC073	Present on Admission Code -12	char	1	POA Indicator for Other Diagnosis – 11. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI11-09

MEDICAL CLAIMS FILE					
CDLMC074	Present on Admission Code -13	char	1	POA Indicator for Other Diagnosis – 12 For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI12-09

MEDICAL CLAIMS FILE					
CDLMC075	Present on Admission Code - 14	char	1	POA Indicator for Other Diagnosis – 13. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI13-09

MEDICAL CLAIMS FILE					
CDLMC076	Present on Admission Code - 15	char	1	POA Indicator for Other Diagnosis – 14. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI14-09

MEDICAL CLAIMS FILE					
CDLMC077	Present on Admission Code - 16	char	1	POA Indicator for Other Diagnosis – 15. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI15-09

MEDICAL CLAIMS FILE					
CDLMC078	Present on Admission Code - 17	char	1	POA Indicator for Other Diagnosis – 16. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI16-09

MEDICAL CLAIMS FILE					
CDLMC079	Present on Admission Code- 18	char	1	POA Indicator for Other Diagnosis – 17. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI17-09

MEDICAL CLAIMS FILE					
CDLMC080	Present on Admission Code - 19	char	1	POA Indicator for Other Diagnosis – 18. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI18-09

MEDICAL CLAIMS FILE					
CDLMC081	Present on Admission Code - 20	char	1	POA Indicator for Other Diagnosis – 19. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI19-09

MEDICAL CLAIMS FILE					
CDLMC082	Present on Admission Code - 21	char	1	POA Indicator for Other Diagnosis – 20. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI20-09

MEDICAL CLAIMS FILE					
CDLMC083	Present on Admission Code - 22	char	1	POA Indicator for Other Diagnosis – 21. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI21-09

MEDICAL CLAIMS FILE					
CDLMC084	Present on Admission Code - 23	char	1	POA Indicator for Other Diagnosis – 22. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI22-09

MEDICAL CLAIMS FILE					
CDLMC085	Present on Admission Code - 24	char	1	POA Indicator for Other Diagnosis – 23. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI23-09

MEDICAL CLAIMS FILE					
CDLMC086	Present on Admission Code - 25	char	1	POA Indicator for Other Diagnosis – 24. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier, leave blank. Report the code that indicates present on admission: Y=Diagnosis was present at time of inpatient admission; N=Diagnosis was not present at time of inpatient admission; U=Documentation insufficient to determine if the condition was present at the time of inpatient admission; W=Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1=Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.	837/2300/ABF/HI24-09
CDLMC087	Revenue Code	char	4	Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements. NUBC Code using leading zeroes, left justified, and four digits. For institutional claims only. Not for professional claims. Revenue codes are maintained by NUBC. See Appendix L: External Code Source, National Uniform Billing Committee.	837/2400/SV201 (I)

MEDICAL CLAIMS FILE					
CDLMC088	Procedure Code	varchar	5	Healthcare Common Procedural Coding System (HCPCS). This includes the CPT codes maintained by the American Medical Association. This field should not include modifiers. Modifiers are submitted in different fields. See Appendix L: External Code Source, American Medical Association.	837/2400/SV202-02 where SV202-01=HC (I) and 837/2400 SV101-02 where SV101-01=HC (P)
CDLMC089	Procedure Modifier – 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, American Medical Association.	837/2400/SV202-03 (I); and 837/2400 SV101-03 (P)
CDLMC090	Procedure Modifier – 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, American Medical Association.	837/2400/SV202-04 (I); and 837/2400 SV101-04 (P)
CDLMC091	Procedure Modifier – 3	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, American Medical Association.	837/2400/SV202-05 (I); and 837/2400 SV101-05 (P)

MEDICAL CLAIMS FILE					
CDLMC092	Procedure Modifier – 4	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, American Medical Association.	837/2400/SV202-06 (I); and 837/2400 SV101-06 (P)
CDLMC093	ICD-9 CM/10- PCS Principal Procedure Code	char	7	Primary procedure code for this line of service. Do not code decimal point. For institutional claims only. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI01-02 where 2300 HI01-01= BBR (ICD10PCS) (I)
CDLMC094	ICD-9 CM/10- CM-PCS Other Procedure Code – 1	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI01-02 where HI01-01=BBQ (ICD-10) (I)
CDLMC095	ICD-9 CM/10-CM-PCS Other Procedure Code – 2	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI02-02 where HI02-01=BBQ (ICD-10) (I)

MEDICAL CLAIMS FILE					
CDLMC096	ICD-9 CM/10-CM-PCS Other Procedure Code – 3	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI03-02 where HI03-01=BBQ (ICD-10) (I)
CDLMC097	ICD-9 CM/10-CM-PCS Other Procedure Code – 4	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI04-02 where HI04-01=BBQ (ICD-10) (I)
CDLMC098	ICD-9 CM/10-CM-PCS Other Procedure Code – 5	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI05-02 where HI05-01=BBQ (ICD-10) (I)
CDLMC099	ICD-9 CM/10-CM-PCS Other Procedure Code – 6	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI06-02 where HI06-01 =BBQ (ICD-10) (I)

MEDICAL CLAIMS FILE					
CDLMC100	ICD-9 CM/10-CM-PCS Other Procedure Code – 7	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI07-02 where HI07-01= BBQ (ICD-10) (I)
CDLMC101	ICD-9 CM/10-CM-PCS Other Procedure Code – 8	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI08-02 where HI08-01=BBQ (ICD-10) (I)
CDLMC102	ICD-9 CM/10-CM-PCS Other Procedure Code –9	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI09-02 where HI09-01=BBQ (ICD-10) (I)
CDLMC103	ICD-9 CM/10-CM-PCS Other Procedure Code – 10	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI10-02 where HI10-01=BBQ (ICD-10) (I)

MEDICAL CLAIMS FILE					
CDLMC104	ICD-9 CM/10-CM-PCS Other Procedure Code – 11	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI11-02 where HI11-01=BBQ (ICD-10) (I)
CDLMC105	ICD-9 CM/10-CM-PCS Other Procedure Code – 12	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI12-02 where HI12-01=BBQ (ICD-10) (I)
CDLMC106	ICD-9 CM/10-CM-PCS Other Procedure Code – 13	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI13-02 where HI13-01=BBQ (ICD-10) (I)
CDLMC107	ICD-9 CM/10-CM-PCS Other Procedure Code – 14	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI14-02 where HI14-01=BBQ (ICD-10) (I)

MEDICAL CLAIMS FILE					
CDLMC108	ICD-9 CM/10-CM-PCS Other Procedure Code – 15	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI15-02 where HI15-01=BBQ (ICD-10) (I)
CDLMC109	ICD-9 CM/10-CM-PCS Other Procedure Code –16	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI16-02 where HI16-01=BBQ (ICD-10) (I)
CDLMC110	ICD-9 CM/10-CM-PCS Other Procedure Code – 17	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI17-02 where HI17-01=BBQ (ICD-10) (I)
CDLMC111	ICD-9 CM/10-CM-PCS Other Procedure Code – 18	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI18-02 where HI18-01=BBQ (ICD-10) (I)

MEDICAL CLAIMS FILE					
CDLMC112	ICD-9 CM/10-CM-PCS Other Procedure Code – 19	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI19-02 where HI19-01=BBQ (ICD-10) (I)
CDLMC113	ICD-9 CM/10-CM-PCS Other Procedure Code – 20	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI20-02 where HI20-01= BBQ (ICD- 10) (I)
CDLMC114	ICD-9 CM/10-CM-PCS Other Procedure Code – 21	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI21-02 where HI21-01=BBQ (ICD- 10) (I)
CDLMC115	ICD-9 CM/10-CM-PCS Other Procedure Code – 22	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI22-02 where HI22-01=BBQ (ICD-10) (I)

MEDICAL CLAIMS FILE					
CDLMC116	ICD-9 CM/10-CM-PCS Other Procedure Code – 23	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI23-02 where HI23-01=BBQ (ICD-10) (I)
CDLMC117	ICD-9 CM/10-CM-PCS Other Procedure Code – 24	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI24-02 where HI24-01=BBQ (ICD-10) (I)
CDLMC118	ICD-9 CM/10-CM-PCS Other Procedure Code – 25	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix L: External Code Source, World Health Organization.	837/2300/HI25-02 where HI25-01=BBQ (ICD-10) (I)
CDLMC119	Date of Service – From	date	8	YYYYMMDD. First date of service for this service line. Filled for all claim types.	837/2300/DTP03 where DTP02=RD8 (I) and 837/2400/DTP03 where DTP01=472
CDLMC120	Date of Service – Thru	date	8	YYYYMMDD Last date of service for this service line. Filled for all claim types.	837/2300/DTP03 where DTP02=RD8 (I) and 837/2400/DTP03 where DTP01=472

MEDICAL CLAIMS FILE					
CDLMC121	Service Units/ Quantity	dec	8,3	Numeric value of quantity. Count of service units performed. The Unit of Measure is typically based on the relevant reporting code (e.g., CPT, revenue, HCPCS). Must include a decimal point when reporting quantities with fractional values up to 3 digits (e.g., 9.999).	837/2400/SV205 (I) and 837/2400/SV104 (P)
CDLMC122	Unit of Measure	varchar	2	Type of units reported in CDLMC121. Example codes: DA=Days; MJ=Minutes; UN=Units. If CDLMC121 is blank (not reported), leave CDLMC122 blank.	837/2400/SV204 (I) and 837/2400/SV103 (P)
CDLMC123	Charge Amount	int	12	The line item charge amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2400/SV203 (I) and 837/2400/SV102 (P)
CDLMC124	Withhold Amount	int	12	A claim-based payment that is included in total medical expense. Report the amount paid to the provider for this claim line if the provider qualified/met performance guarantees. Report 0 if there is no withhold amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLMC125	Plan Paid Amount	int	12	This is the service line paid amount. This excludes the patient liability. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/SVD02

MEDICAL CLAIMS FILE					
CDLMC126	Co-Pay Amount	int	12	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the co-pay amount on the first claim line. Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/CAS03 where CAS02 is 3
CDLMC127	Coinsurance Amount	int	12	The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/CAS03 where CAS02 is 2
CDLMC128	Deductible Amount	int	12	Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/CAS03 where CAS02 is 1

MEDICAL CLAIMS FILE					
CDLMC129	Other Insurance Paid Amount	int	12	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report "0" if the prior payer paid 0 toward this claim line; or if there is no prior payer. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	N/A
CDLMC130	COB/TPL Amount	int	12	Payer paid amount from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2320/AMT02 where AMT01 = D
CDLMC131	Allowed Amount	int	12	When payment arrangement type in CDLMC132 is equal to 01 for capitated services, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. When payment arrangement type in CDLMC132 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2300/HCP02

MEDICAL CLAIMS FILE					
CDLMC132	Payment Arrangement Type Indicator	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 04=DRG; 05=Pay for Performance; 06=Global Payment; 07=Other; 08=Bundled Payment.	N/A
CDLMC133	Drug Code	char	11	Report the NDC code only when a medication is paid for as part of a medical claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. If not available, leave blank. See Appendix L: External Code Source, United States Food and Drug Administration.	837/2410/LIN03 where LIN02=N4 (I)
CDLMC134	Rendering Provider ID	varchar	35	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that provided the services on the claims. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	837/2010AA/REF02 where REF01=G2 (I) and 837/2420A/REF02 where REF01=G2 (P) or 837/2310B/REF02 where REF01=G2 (P)

MEDICAL CLAIMS FILE					
CDLMC135	Rendering Provider NPI	char	10	Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES.	837/2010AA/NM109 where NMI08 = XX (I) and 837/2420A/NM109 where NM108 = XX (P) or 837/2310B/NM109 where NM108 = XX (P)
CDLMC136	Rendering Provider Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or "non-person entity". HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1=Person; 2=Non-Person Entity.	837/2010AA/NM102 (I) and 837/2420A/NM102 (P) or 837/2310B/NM102 (P)
CDLMC137	In Plan Network Indicator	char	1	A yes/no indicator that specifies if the provider (not the benefit) is within the health plan network. Valid codes are: N=No; Y=Yes; L=Leased Network.	N/A
CDLMC138	Rendering Provider First Name	varchar	35	Individual first name. If CDLMC136=2, leave blank.	837/2010AA/NM104 (I) and 837/2420A/NM104 (P) or 837/2310B/NM104 (P)

MEDICAL CLAIMS FILE					
CDLMC139	Rendering Provider Middle Name	varchar	25	Individual middle name or initial. If CDLMC136=2, leave blank.	837/2010AA/NM105 (I) and 837/2420A/NM105 (P) or 837/2310B/NM105 (P)
CDLMC140	Rendering Provider Last Name or Organization Name	varchar	60	Full name of provider organization ("non-person entity") or last name of individual ("person") provider. CDLMC136 determines if the Rendering Provider is a "person" or a "non-person entity".	837/2010AA/NM103 (I) and 837/2420A/NM103 (P) or 837/2310B/NM103 (P)
CDLMC141	Rendering Provider Suffix	varchar	10	Suffix of Rendering Provider. Leave blank if provider is a facility or organization. The rendering provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD.	837/2010AA/NM107 (I) and 837/2420A/NM107 (P) or 837/2310B/NM107 (P)
CDLMC142	Rendering Provider Specialty	varchar	10	Standard code that identifies the provider specialty for this line of service. Report the HIPAA-compliant healthcare provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix L: External Code Source, National Uniform Claims Committee.	837/2010AA/PRV03 where PRV02 = PXC (I) and 837/2420A/PRV03 (P) or 837/2310B/PRV03 (P)
CDLMC143	Rendering Provider City Name	varchar	30	City where the rendering provider delivered the service.	837/2010AA/N401 (I) and 837/2420C/N401 (P) or 837/2310C/N401 (P)

MEDICAL CLAIMS FILE					
CDLMC144	Rendering Provider State or Province	char	2	State or Province where the rendering provider delivered the service. Codes are maintained by the US Postal Service. See Appendix L: External Code Sources, United States Postal Service.	837/2010AA/N402 (I) and 837/2420C/N402 (P) or 837/2310C/N402 (P)
CDLMC145	Rendering Provider ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the address where the rendering provider delivered the service. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix L: External Code Sources.	837/2010AA/N403 (I) and 837/2420C/N403 (P) or 837/2310C/N403 (P)
CDLMC146	Rendering Provider Group Practice NPI	char	10	NPI of group practice to which a rendering provider is affiliated if different from CDLMC135.	N/A
CDLMC147	Billing Provider ID	varchar	35	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	837/2010AA/REF02 where REF01=G2
CDLMC148	Billing Provider NPI	char	10	NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	837/2010AA/NM109 where NM108=XX
CDLMC149	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	837/2010AA/NM103
CDLMC150	Billing Provider Tax ID	char	9	Tax ID of the billing provider. Do not code punctuation.	837/2010AA/REF02 where REF01=EI

MEDICAL CLAIMS FILE					
CDLMC151	Referring Provider ID	varchar	35	Payer assigned provider ID for the referring provider. The Referring Provider is the provider who directed the patient for care to the provider that rendered the services being submitted on the claim form. The Referring Provider Number is the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not available, leave blank.	837/2310F/REF02 where REF01=G2 (I) and 837/2310A/REF02 where REF01=G2 (P) or 837/2420F/REF02 where REF01=G2 (P)
CDLMC152	Referring Provider NPI	char	10	NPI of the referring provider. The referring provider is the entity or individual that submitted the referral of the service or procedure. The Referring Provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form. If not available, leave blank.	837/2310F/NM109 where NM108=XX (I) and 837/2310A/NM109 where NM108=XX (P) or 837/2420F/NM109 where NM108=XX (P)
CDLMC153	Attending Provider ID	varchar	35	Payer assigned provider ID for the attending provider. On the institutional claim, the Attending Provider is the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending Provider Number is the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not available, leave blank.	837/2310A/REF02 where REF01=G2 (I)

MEDICAL CLAIMS FILE					
CDLMC154	Attending Provider NPI	char	10	NPI of the attending provider. On the institutional claim, the Attending Provider is the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending and Rendering provider can be the same individual. If not available, leave blank.	837/2310A/NM109 where NM108=XX (I)
CDLMC155	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved- out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. If not available, leave blank. See Appendix L: External Code Source, National Association of Insurance Commissioners.	N/A
CDLMC156	Type of Claim	int	1	Indicates the type of claim that was submitted. Valid codes are: 1=Professional; 2=Institutional/ Facility; 3=Reimbursement Form (Member).	N/A

MEDICAL CLAIMS FILE					
CDLMC157	Claim Status	char	2	01=Processed as primary; 02=Processed as secondary; 03=Processed as tertiary; 04=Denied; 19=Processed as primary, forwarded to additional payer(s); 20=Processed as secondary, forwarded to additional payer(s); 21=Processed as tertiary, forwarded to additional payer(s); 22=Reversal of previous payment; 23=Not our claim, forwarded to additional payer(s); 25=Predetermination pricing only – No payment.	835/2100/CLP02
CDLMC158	Denied Claim Line Indicator	int	1	Use this field to indicate whether the payer denied this specific line on this specific claim. Valid codes are: 1=Yes (denied); 2=No (not denied).	N/A
CDLMC159	Claim adjustment reason code	varchar	3	Report the claim adjustment reason code. If CDLMC158=1, report the code that defines the reason for denial of the claim line. If not available, leave blank. Reason codes are maintained by ANSI ASC X12. See Appendix L: External Code Source, Accredited Standards Committee.	837/2430/CAS02

MEDICAL CLAIMS FILE					
CDLMC160	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment; D=Denial.	N/A
CDLMC161	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLMC162	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLMC163	Rendering Provider Street Address	varchar	55	First line of street address where the rendering provider delivered the service (street number and street name). Include suite number if applicable.	837/2010AA/N301 (I) and 837/2420C/N301 (P) or 837/2310C/N301 (P)
CDLMC164	Medical Record Number	varchar	35	Medical record number of the member.	837/2300/REF02 when REF01=EA
CDLMCXXX	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLMC899	Record Type	char	2	Value=MC	N/A

D. Pharmacy Claims File (PC)

This file accommodates data on service-level claims and remittance information for prescription drug claims, including member demographics, provider details, payment amounts, and national drug codes (NDC). References to the NCPDP Uniform Healthcare Payer Data Standard Implementation are provided.

PHARMACY CLAIMS FILE					
Element #	**Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi- tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLPC002).	N/A
CDLPC002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi- tiered to support different platforms).	879-N2
CDLPC003	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	569-J8
CDLPC004	Member Insurance/ Product Category code	char	2	See Appendix J: Insurance Type/Product Category for codes. Use the most granular choice available. Code reported must align with the member's enrollment product (CDLME004) during the time of service.	A90* *With additional values outlined in Appendix J

PHARMACY CLAIMS FILE					
CDLPC005	Payer Claim Control Number	varchar	35	NCPDP refers to this field as Internal Control Number. Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLPC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	993-A7
CDLPC006	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	A91
CDLPC007	Version Number	int	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, Cross Reference Claims ID (CDLPC008) is to be utilized.	102-A2
CDLPC008	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLPC005). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLPC007) is not used.	N/A

PHARMACY CLAIMS FILE						
CDLPC009	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLPC009 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, then report a value of "IND". If a policy is sold to an individual as a non-group policy, then report with a value of "IND".		246
CDLPC010	Medicaid AID Category	varchar	10	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A	
CDLPC011	Subscriber Social Security Number	char	9	Subscriber's Social Security Number. Do not include dashes. Leave blank if not collected.	A89	
CDLPC012	Plan Specific Contract Number	varchar	80	Plan assigned subscriber's contract number (NCPDP refers to this as the Cardholder ID). If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid claim, provide Medicaid ID.	302-C2	
CDLPC013	Subscriber Last Name	varchar	60	The subscriber's last name.		716
CDLPC014	Subscriber First Name	varchar	35	The subscriber's first name.		717
CDLPC015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.	303-C3	

PHARMACY CLAIMS FILE						
CDLPC016	Member Social Security Number	char	9	Member's Social Security Number. When the member is the subscriber, use subscriber social security number. Do not include dashes. Leave blank if not collected.	332-CY	
CDLPC017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes maintained by ANSI ASC X12. See Appendix L: External Code Source.		247
CDLPC018	Member Sex	char	1	Sex of the Member. 1=Male; 2=Female; 0=Unspecified. Member sex represents biological or administrative sex. If the member is the subscriber, report the subscriber's sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values).	305-C5	
CDLPC019	Member Date of Birth	date	8	YYYYMMDD; Date of birth of member. If the member is the subscriber, report the subscriber's date of birth.	304-C4	
CDLPC020	Member Last Name	varchar	60	Member last name. If the member is the subscriber, report the subscriber's last name.		716
CDLPC021	Member First Name	varchar	35	Member first name. If the member is the subscriber, report the subscriber's last name.		717

PHARMACY CLAIMS FILE					
CDLPC022	Member ZIP Code	varchar	9	Report the 5- or 9-digit ZIP Code of the member's residence. If the member is the subscriber, report the Zip Code of the subscriber's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix L: External Code Sources.	730-TC
CDLPC023	Date Prescription Filled	date	8	YYYYMMDD. Date the prescription was filled.	401-D1
CDLPC024	Paid Date	date	8	YYYYMMDD. Check Date or Adjudication Date of the claim line. Report the date that appears on the: check, and/or remit, and/or explanation of benefits, and corresponds to all types of payment in YYYYMMDD Format. If paid/adjudicated date is not available, use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here.	216 or 578
CDLPC025	Drug Code	char	11	NDC Code for the drug on the claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. See Appendix L: External Code Source, United States Federal Drug Administration.	407-D7
CDLPC026	New Prescription or Refill	char	2	Provide '00' for new prescriptions; for refills, provide the refill number. 00=New prescription; 01–99=Refill.	254
CDLPC027	Generic Drug Indicator	char	2	Indicates whether the drug itself is generic, not how the payer pays it. Valid codes are: 01=Branded drug; 02=Generic drug.	425-DP

PHARMACY CLAIMS FILE					
CDLPC028	Dispensed as Written Code	char	1	Use this field to indicate how the drug was dispensed: 0=No Product Selection Indicated (may also have missing values); 1=Substitution Not Allowed by Prescriber; 2=Substitution Allowed - Patient Requested That Brand Product Be Dispensed; 3=Substitution Allowed - Pharmacist Selected Product Dispensed; 4=Substitution Allowed - Generic Drug Not in Stock; 5=Substitution Allowed - Brand Drug Dispensed as Generic; 6=Override; 7=Substitution Not Allowed - Brand Drug Mandated by Law; 8=Substitution Allowed - Generic Drug Not Available in Marketplace; 9=Other.	408-D8
CDLPC029	Compound Drug Indicator	char	1	Use this field to indicate whether the drug is a compound drug or non-compound drug. Valid codes are: N=Non-compound drug; Y=Compound drug; U=Unknown.	406-D6
CDLPC030	Drug Name or Compound Drug Ingredient List	char	128	Use this field to report the name of the drug dispensed. If CDLPC029=Y, then provide the names of the compound drug ingredients. Use a semi-colon (;) delimiter to separate multiple compound drug ingredients.	N/A

PHARMACY CLAIMS FILE					
CDLPC031	Formulary Indicator	char	1	Use this field to report if the prescribed drug was on the carrier's formulary list. Valid codes include: 1=Yes; 2=No; 3=Unknown; 4=Other; 5=Not applicable.	N/A
CDLPC032	Quantity Dispensed	dec	10,2	Quantity dispensed.	442-E7
CDLPC033	Days' Supply	int	3	Estimated number of days the prescription will last.	405-D5
CDLPC034	Drug Unit of Measure	varchar	3	Report the code that defines the unit of measure for the drug dispensed in PC033. Valid codes are: EA=Each; F2=International Units; GM=Grams; ML=Milliliters; MG=Milligrams; MEQ=Milliequivalent; MM=Millimeter; UG=Microgram; UU=Unit; OT=Other.	N/A
CDLPC035	Prescription Number	varchar	20	Report the unique prescription identifier.	254 (fill number calculated)
CDLPC036	Charge Amount	int	10	NCPDP refers to this as Gross Amount Due. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	430-DU

PHARMACY CLAIMS FILE						
CDLPC037	Plan Paid Amount	int	10	NCPDP refers to this as Net Amount Due. Includes all health plan payments and excludes all member payments. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).		281
CDLPC038	Allowed Amount	int	12	When payment arrangement type in CDLPC049 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a prescription. When payment arrangement type in CDLPC049 is equal to 02 for fee for service, report the maximum amount contractually allowed. Report 0 if there is no allowed amount Do not code decimal point or provide any punctuation (e.g. $1,000.25 converted to 100025).	N/A	
CDLPC039	Sales Tax Amount	int	12	Report the amount of state sales tax applied to this claim line. Report 0 if there is no state tax amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up / down to whole dollars, code zero cents (00) when applicable.	558-AW	
CDLPC040	Ingredient Cost/List Price	int	10	Cost of the drug dispensed. Report 0 if there is no Ingredient Cost/List Price Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	506-F6	
CDLPC041	Postage Amount Claimed	int	10	Postage amount associated with the claim. Report 0 if there is no Postage Amount Claimed Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A	

PHARMACY CLAIMS FILE					
CDLPC042	Dispensing Fee	int	10	Dispensing fee associated with the claim Report 0 if there is no Dispensing Fee. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	507-F7
CDLPC043	Co-Pay Amount	int	10	Actual co-payment dollar amount paid for which the individual is responsible. (e.g., If the fixed amount is $25 but the cost to the member is $4 report, 400.) Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	518-FI
CDLPC044	Coinsurance Amount	int	10	The dollar amount of coinsurance for this claim line for which an individual is responsible, not the percentage. Report 0 if no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	572-4U
CDLPC045	Deductible Amount	int	10	The dollar amount for this claim line applied to the deductible. Report 0 if there is no deductible amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	517-FH
CDLPC046	COB/TPL Amount	int	12	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/ TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A

PHARMACY CLAIMS FILE					
CDLPC047	Other Insurance Paid Amount	int	10	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report "0" if the prior payer paid 0 toward this claim line; or if there is no prior payer. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	565-J4
CDLPC048	Member Self-Pay Amount	int	12	Report the amount that the member has paid beyond the other patient obligations (e.g., gap on Medicare Part D, or difference between generic and brand) that are not otherwise listed in the file in CDLPC043, CDLPC044, CDLPC045. Report "0" if there is no member Self-Pay Amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up / down to whole dollars, code zero cents (00) when applicable.	505-F5
CDLPC049	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 07=Other.	N/A
CDLPC050	Prescribing Physician ID	varchar	35	Payer assigned provider ID for the prescribing physician. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	N/A

PHARMACY CLAIMS FILE						
CDLPC051	Prescribing Physician NPI	char	10	NPI number for prescribing physician.	411-DB	
CDLPC052	Prescribing Physician First Name	varchar	25	Prescribing Physician's first name or initial.	A92	
CDLPC053	Prescribing Physician Last Name	varchar	60	Prescribing Physician's last name.		716
CDLPC054	Pharmacy NCPDP Number	varchar	7	Unique 7-digit number assigned by the National Council for Prescription Drug Program (NCPDP).	N/A	
CDLPC055	Pharmacy ID	varchar	35	Payer assigned pharmacy ID. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	201-B1	
CDLPC056	Pharmacy Tax ID Number	char	9	Dispensing pharmacy federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBMs may not have this data).	N/A	
CDLPC057	Pharmacy NPI	char	10	NPI of the entity or individual (pharmacy) directly providing the service.	201-B1	
CDLPC058	Pharmacy Location Street Address	varchar	55	First line of street address of pharmacy that dispensed the prescription, including street number, name. Include suite number if applicable. Relates to CDLPC059-CDLPC061.	728-SU	
CDLPC059	Pharmacy Location State	char	2	State or Province where dispensing pharmacy located. State or Province codes are maintained by the US Postal Service. See Appendix L: External Code Sources, United States Postal Service.	729-TA	

PHARMACY CLAIMS FILE					
CDLPC060	Pharmacy ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the Pharmacy. When submitting the 9-digit ZIP Code, do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix L: External Code Sources.	730-TC
CDLPC061	Pharmacy Country Code	char	2	Country where dispensing pharmacy located. Report two-digit code. Code US for United States. See Appendix L: External Code Sources, United States Postal Service	A93-1T
CDLPC062	Mail-Order Pharmacy Indicator	int	1	Use this field to report if the pharmacy was a mail-order pharmacy. Valid codes include: 1=Yes, mail order pharmacy; 2=No, not a mail order pharmacy; 3=Unknown; 4=Other; 5=Not applicable.	N/A
CDLPC063	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. See Appendix L: External Code Source, National Association of Insurance Commissioners.	N/A

PHARMACY CLAIMS FILE					
CDLPC064	In Plan Network Indicator	char	1	Use this field to specify if services from the requested provider were provided within the health plan network. Valid values are: N=No; Y=Yes; L=Leased Network.	N/A
CDLPC065	Record Status Code	char	1	01=Processed as primary; 02=Processed as secondary; 03=Processed as tertiary; 04=Denied; 19=Processed as primary, forwarded to additional payer(s); 20=Processed as secondary, forwarded to additional payer(s); 21=Processed as tertiary, forwarded to additional payer(s); 22=Reversal of previous payment; 23=Not our claim, forwarded to additional payer(s); 25=Predetermination pricing only – No payment.	N/A
CDLPC066	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment; D=Denial.	N/A

PHARMACY CLAIMS FILE					
CDLPC067	Reject Code	varchar	3	Report the reason code for the denial. Report the code that defines the reason for denial of the claim line. If not available, leave blank. Reason codes are maintained by NCPDP. See Appendix L: External Code Source, NCPDP.	511-FB
CDLPC068	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLPC069	Carrier Specific Unique Subscriber ID	char	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLPC070	Prescriber Specialty	varchar	10	Report the NUCC healthcare provider taxonomy code. See Appendix L: External Code Source, National Uniform Claim Committee.	296
CDLPC071	Pharmacy City	varchar	30	City or town where dispensing pharmacy located.	728-SU
CDLPCXXX	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLPC899	Record Type	char	2	Value=PC	N/A

E. Dental Claims File (DC)

This file accommodates data on service-level claims and remittance information for dental services, including member demographics, provider details, payment amounts, clinical diagnosis codes, and procedure codes. References to the relevant ASC X12 transactions are provided.

DENTAL CLAIMS FILE

Element #	Element Name	Type	Max Length	Description/ Codes/ Sources	ASC X12N PACDR and 835 References
CDLDC001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLDC002).	N/A
CDLDC002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLDC003	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	837/2330A/NM109 where NM108=PI
CDLDC004	Member Insurance/ Product Category code	char	2	See Appendix J: Insurance Type/Product Category for codes. Use the most granular choice available. Code reported must align with the member's enrollment product (CDLME004) during the time of service.	837/2320/SBR09* *With additional values outlined in Appendix J

DENTAL CLAIMS FILE					
CDLDC005	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLDC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	837/2330A/REF02 where REF01=F8
CDLDC006	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	837/2400/LX01
CDLDC007	Version Number	int	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, use Cross Reference Claims ID (CDLDC008).	N/A
CDLDC008	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLDC005) Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLDC007) is not used.	N/A

DENTAL CLAIMS FILE					
CDLDC009	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLDC009 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, then report a value of "IND". If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	837/2320A/SBR03
CDLDC010	Medicaid AID Category	varchar	10	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A
CDLDC011	Subscriber Social Security Number	char	9	Subscriber's Social Security Number. Do not include dashes. Leave blank if not collected	837/2010BA/REF02 where REF01=SY
CDLDC012	Plan Specific Contract Number	varchar	80	Plan assigned contract number. If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid claim, provide the Medicaid ID.	837/2010BA/NM109 where NM108=MI
CDLDC013	Subscriber Last Name	varchar	60	The subscriber's last name.	837/2010BA/NM103
CDLDC014	Subscriber First Name	varchar	35	The subscriber's first name.	837/2010BA/NM104
CDLDC015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.	N/A

DENTAL CLAIMS FILE					
CDLDC016	Member Social Security Number	char	9	Member's Social Security Number. If the member is the subscriber, report the subscriber's SSN. Do not include dashes. Leave blank if not collected.	Subscriber: 837/2010BA/REF02 where REF01=SY Member/Patient: 837/2010CA/REF02 where REF01=SY
CDLDC017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes maintained by ANSI ASC X12. See Appendix L: External Code Source, Accredited Standards Committee.	Subscriber: 837/2000B/SBR02 Member: 837/2000C/PAT01
CDLDC018	Member Sex	char	1	Sex of the Member. M=Male; F=Female; U=Unknown. Member sex represents biological or administrative sex. If the member is the subscriber, report the subscriber's sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values).	Subscriber: 837/2010BA/DMG03 Member/Patient: 837/2010CA/DMG03
CDLDC019	Member Date of Birth	date	8	YYYYMMDD. Date of birth of member. If the member is the subscriber, report the subscriber's date of birth.	Subscriber: 837/2010BA/DMG02 Member/Patient: 837/2010CA/DMG02

DENTAL CLAIMS FILE					
CDLDC020	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	Subscriber: 837/2010BA/NM103 Member/Patient: 837/2010CA/NM103
CDLDC021	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	Subscriber: 837/2010BA/NM104 Member/Patient: 837/2010CA/NM104
CDLDC022	Member ZIP Code	varchar	9	Report the 5- or 9-digit ZIP Code of the member's residence. If the member is the subscriber, report the Zip Code of the subscriber's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix L: External Code Sources.	Subscriber: 837/2010BA/N403 Member/Patient: 837/2010CA/N403
CDLDC023	Paid Date	date	8	YYYYMMDD. Paid date of the claim line. Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to all types of payment in YYYYMMDD format. If paid/adjudicated date is not available, use Processed Date. Claims paid in full, partial, or zero paid must have a date reported.	837/2330A/DTP03 where DTP01=57
CDLDC024	Place of Service–Professional	char	2	Required for professional claims. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix L: External Code Source, Center for Medicaid and Medicare Services.	837/2300/CLM05-01 where CLM05-02=B

DENTAL CLAIMS FILE					
CDLDC025	ICD 10-CM Diagnosis Code	varchar	7	ICD 10-CM Diagnosis Code when applicable. See Appendix L: External Code Source.	837/2300/HI01-2 where HI01-01=ABF (ICD-10)
CDLDC026	ICD-9/ICD-10 Flag	char	1	The purpose of this field is to identify which code set is being utilized. 9=This claim contains ICD-9- CM codes; 0=This claim contains ICD-10-CM codes.	N/A
CDLDC027	Procedure Code	varchar	5	Common Dental Terminology (CDT) or Current Procedure Terminology (CPT) code for the dental procedure on the claim. CDT codes are maintained by American Dental Association. See Appendix L: External Code Source, American Dental Association. CPT codes are maintained by the American Medical Association. See Appendix L: External Code Source, American Medical Association.	837/2400/SV301-02 where SV301-01=AD
CDLDC028	Oral Cavity 1	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity; 01=maxillary arch; 02=mandibular arch; 10=upper right quadrant; 20=upper left quadrant; 30=lower left quadrant; 40=lower right quadrant.	837/2400/SV304-01

DENTAL CLAIMS FILE					
CDLDC029	Oral Cavity 2	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity; 01=maxillary arch; 02=mandibular arch; 10=upper right quadrant; 20=upper left quadrant; 30=lower left quadrant; 40=lower right quadrant.	837/2400/SV304-02
CDLDC030	Oral Cavity 3	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity; 01=maxillary arch; 02=mandibular arch; 10=upper right quadrant; 20=upper left quadrant; 30=lower left quadrant; 40=lower right quadrant.	837/2400/SV304-03

DENTAL CLAIMS FILE					
CDLDC031	Oral Cavity 4	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity; 01=maxillary arch; 02=mandibular arch; 10=upper right quadrant; 20=upper left quadrant; 30=lower left quadrant; 40=lower right quadrant.	837/2400/SV304-04
CDLDC032	Oral Cavity 5	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity; 01=maxillary arch; 02=mandibular arch; 10=upper right quadrant; 20=upper left quadrant; 30=lower left quadrant; 40=lower right quadrant.	837/2400/SV304-05

DENTAL CLAIMS FILE					
CDLDC033	Tooth Number or Letter (1)	varchar	2	Required when CDLDC027=D2000 thru D2999. Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. If not available, leave blank. Tooth Number codes are maintained by the American Dental Association. See Appendix L: External Code Source, American Dental Association.	837/2400/TOO02
CDLDC034	Tooth – 1 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	837/2400/TOO03-01
CDLDC035	Tooth – 1 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	837/2400/TOO03-02
CDLDC036	Tooth – 1 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	837/2400/TOO03-03
CDLDC037	Tooth – 1 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	837/2400/TOO03-04
CDLDC038	Tooth – 1 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	837/2400/TOO03-05

DENTAL CLAIMS FILE					
CDLDC039	Tooth Number or Letter (2)	varchar	2	Report the tooth identifier(s) when CDLDC027 is within the given range if a second tooth is involved in the procedure. Required when CDLDC027=D2000 thru D2999. See Appendix L: External Code Source, American Dental Association.	837/2400/TOO02
CDLDC040	Tooth – 2 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	837/2400/TOO03-01
CDLDC041	Tooth – 2 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	837/2400/TOO03-02
CDLDC042	Tooth – 2 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	837/2400/TOO03-03
CDLDC043	Tooth – 2 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	837/2400/TOO03-04
CDLDC044	Tooth – 2 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	837/2400/TOO03-05

DENTAL CLAIMS FILE					
CDLDC045	Tooth Number or Letter (3)	varchar	2	Report the tooth identifier(s) when CDLDC027 is within the given range if a third tooth is involved in the procedure. Required when CDLDC027=D2000 thru D2999. See Appendix L: External Code Source, American Dental Association.	837/2400/TOO02
CDLDC046	Tooth – 3 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	837/2400/TOO03-01
CDLDC047	Tooth – 3 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	837/2400/TOO03-02
CDLDC048	Tooth – 3 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	837/2400/TOO03-03
CDLDC049	Tooth – 3 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	837/2400/TOO03-04
CDLDC050	Tooth – 3 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	837/2400/TOO03-05

DENTAL CLAIMS FILE					
CDLDC051	Tooth Number or Letter (4)	varchar	2	Report the tooth identifier(s) when CDLDC027 is within the given range if a fourth tooth is involved in the procedure. Required when CDLDC027=D2000 thru D2999. See Appendix L: External Code Source, American Dental Association.	837/2400/TOO02
CDLDC052	Tooth – 4 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	837/2400/TOO03-01
CDLDC053	Tooth – 4 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	837/2400/TOO03-02
CDLDC054	Tooth – 4 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	837/2400/TOO03-03
CDLDC055	Tooth – 4 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	837/2400/TOO03-04
CDLDC056	Tooth – 4 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	837/2400/TOO03-05

DENTAL CLAIMS FILE					
CDLDC057	Date of Service – From	date	8	YYYYMMDD. First date of service for this service line. Filled for all claim types. (This date should be within the coverage period on the Eligibility file i.e. between the Plan Effective Date and the Plan Term Date on the Eligibility file all inclusive).	837/2400/DTP03 where DTP01=472 (service line) or 837/2300/DTP03 where DTP01=434
CDLDC058	Date of Service – Thru	date	8	YYYYMMDD Last date of service for this service line. Filled for all claim types.	837/2400/DTP03 where DTP01=472 (service line) or 837/2300/DTP03 where DTP01=434
CDLDC059	Charge Amount	int	12	Amount charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2400/SV302
CDLDC060	Plan Paid Amount	int	12	Service line paid amount. This excludes the patient liability. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/SVD02
CDLDC061	Co-pay Amount	int	12	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the co-pay amount on the first claim line. Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430 CAS03 where CAS02=3 (service line) and 837/2320A/CAS03 where CAS02=3

DENTAL CLAIMS FILE					
CDLDC062	Coinsurance Amount	int	12	The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/CAS03 where CAS02=2 (service line) and 837/2320A/CAS03 where CAS02=2 (claim)
CDLDC063	Deductible Amount	int	12	Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/CAS03 where CAS02=1 (service line) and 837/2320/CAS03 where CAS02=1 (claim)
CDLDC064	Repriced Allowed Amount	Int	12	When payment arrangement type in CDLDC065 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a particular procedure or service. When payment arrangement type in CDLDC065 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay for a particular procedure or service. Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g. $1,000.25 converted to 100025).	837/2400/HCP02 (service line) and 837/2300/HCP02 (claim)

DENTAL CLAIMS FILE					
CDLDC065	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 07=Other.	N/A
CDLDC066	Rendering Provider ID	varchar	35	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that provided the services on the claims. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	837/2420A/REF02 where REF01=G2 (service line) or 837/2310B/REF02 where REF01=G2 (claim)
CDLDC067	Rendering Provider NPI	char	10	Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES.	837/2420A/NM109 where NM108 = XX (service line) or 837/2310B/NM109 where NM108 = XX (claim)
CDLDC068	Rendering Provider Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or "non-person entity". HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1=Person; 2=Non- Person Entity.	837/2420A/NM102 or 837/2310B/NM102

DENTAL CLAIMS FILE					
CDLDC069	Rendering Provider First Name	varchar	35	Individual first name. If CDLDC068=2, leave blank.	837/2420A/NM104 or 837/2310B/NM104
CDLDC070	Rendering Provider Middle Name	varchar	25	Individual middle name or initial. If CDLDC068=2, leave blank.	837/2420A/NM105 or 837/2310B/NM105
CDLDC071	Rendering Provider Last Name or Organization Name	varchar	60	Full name of provider organization ("non-person entity") or last name of individual ("person") provider. CDLDC068 determines if the rendering provider is a "person" or a "non-person entity".	837/2420A/NM103 or 837/2310B/NM103
CDLDC072	Rendering Provider Suffix	varchar	10	Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III).	837/2420A/NM107 or 837/2310B/NM107
CDLDC073	Rendering Provider Specialty	varchar	10	Standard code that identifies the provider specialty for this line of service. Report the HIPAA-compliant healthcare provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix L: External Code Source, National Uniform Claims Committee.	837/2420A/PRV03 or 837/2310B/PRV03
CDLDC074	Rendering Provider City Name	varchar	30	City name of provider or practice location.	837/2420C/N401 or 837/2310C/N401
CDLDC075	Rendering Provider State or Province	char	2	State of provider or practice location. State or Province codes are maintained by the US Postal Service. See Appendix L: External Code Sources, United States Postal Service.	837/2420C/N402 or 837/2310C/N402

DENTAL CLAIMS FILE					
CDLDC076	Rendering Provider ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the Rendering Provider. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix L: External Code Sources.	837/2420C/N403 or 837/2310C/N403
CDLDC077	Rendering Provider Group Practice NPI	varchar	10	NPI of rendering provider group practice to which a practitioner is affiliated if different from CDLDC067.	N/A
CDLDC078	Billing Provider ID	varchar	35	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	837/2010AA/REF02 where REF01=G2
CDLDC079	Billing Provider NPI	char	10	NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	837/2010AA/NM109 where NM108=XX
CDLDC080	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	837/2010AA/NM103
CDLDC081	Billing Provider Tax ID	varchar	10	Tax ID of the billing provider. Do not code punctuation.	N/A

DENTAL CLAIMS FILE					
CDLDC082	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved- out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. If not available, leave blank. See Appendix L: External Code Source, National Association of Insurance Commissioners.	N/A
CDLDC083	Claim Status	char	2	01=Processed as primary; 02=Processed as secondary; 03=Processed as tertiary; 04=Denied; 19=Processed as primary, forwarded to additional payer(s); 20=Processed as secondary, forwarded to additional payer(s); 21=Processed as tertiary, forwarded to additional payer(s); 22=Reversal of previous payment; 23=Not our claim, forwarded to additional payer(s); 25=Predetermination pricing only – No payment.	835/2100/CLP02

DENTAL CLAIMS FILE					
CDLDC084	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment; D=Denial.	N/A
CDLDC085	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLDC086	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLDCXXX	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLDC899	Record Type	char	2	Value=DC	N/A

F. Provider File (PV)

This file accommodates data on provider information, including provider IDs, National Provider Identifiers (NPI), names, specialty codes, and practice locations. It includes providers associated with eligibility, claims, and NCP data files during the reporting period.

PROVIDER FILE				
Element #	**Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLPV002).
CDLPV002	Payer Code	varchar	8	APCD-assigned identifier of insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLPV003	Plan ID	varchar	30	CMS National Plan ID. The national plan ID is a code assigned by CMS. (PLACEHOLDER).
CDLPV004	Payer Assigned Provider ID	varchar	35	Unique code identified for the provider as assigned by the reporting entity. For every provider included in the Eligibility, Medical, Pharmacy and Dental claims, the payer assigned provider IDs shall be included.
CDLPV005	Provider Tax ID	char	9	Tax ID of the provider. Do not code punctuation.
CDLPV006	Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1=Person; 2=Non-Person Entity.
CDLPV007	Provider NPI	char	10	NPI for provider as enumerated in the Center for Medicaid and Medicare Services NPPES.
CDLPV008	Provider DEA Number	varchar	12	Provider Drug Enforcement Agency number. For all prescribing providers (CDLPC050) that have a DEA number.

PROVIDER FILE				
CDLPV009	Provider State License Number	varchar	15	Prefix with two-character state of licensure with no punctuation. Example: COLL12345. Do not leave a blank space in between state and license number.
CDLPV010	Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.
CDLPV011	Provider Middle Name or Initial	varchar	25	Individual middle name or initial. If provider is a facility or organization, leave blank.
CDLPV012	Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider.
CDLPV013	Provider Suffix	varchar	10	Suffix to individual name. If provider is a facility or organization, leave blank. The provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD.
CDLPV014	Provider Office Street Address	varchar	55	First line of the street address for the physical location where the provider delivers healthcare services (street number and street name). Include suite number if applicable. Multiple addresses will require multiple provider records.
CDLPV015	Provider Office City	varchar	30	The city of the physical address where the provider delivers healthcare services. Multiple addresses will require multiple provider records.
CDLPV016	Provider Office State	char	2	The state of the physical address where the provider delivers healthcare services. Use postal service standard 2 letter abbreviations. Multiple addresses will require multiple provider records. See Appendix L: External Code Source, United States Postal Service.
CDLPV017	Provider Office ZIP Code	varchar	9	Report the 5- or 9-digit ZIP Code of the Rendering Provider. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Multiple addresses will require multiple provider records. ZIP Codes are maintained by the US Postal Service. See Appendix L: External Code Source.

PROVIDER FILE				
CDLPV018	Provider FIPS County Code	char	5	Report the FIPS county code based on the provider's address. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. If member lives outside US, leave blank. See Appendix L: External Code Source, United States Census Bureau.
CDLPV019	Provider Country Code	char	2	Country of provider's practice location. Report two-digit code. Code US for United States. See Appendix L: External Code Source, United States Postal Service.
CDLPV020	Provider Phone	char	10	Phone number of Provider.
CDLPV021	Provider Specialty	varchar	10	Report the NUCC healthcare provider taxonomy code. See Appendix L: External Code Source, National Uniform Claim Committee.
CDLPV022	Atypical Provider Taxonomy Code	varchar	10	Non-medical or atypical providers not defined as covered entities by CMS. Non-medical providers who supply non-healthcare services, such as non-emergency transportation, will continue to submit claims and other transactions using their current provider ID and taxonomy. Use Code set for Atypical Provider Taxonomy Codes (maintained by NUCC). If not applicable, leave blank. See Appendix L: External Code Source, National Uniform Claim Committee.
CDLPV023	Medicare Provider ID	varchar	10	Provider ID as assigned by Medicare. Use CMS Certification Number (CCN) found in Appendix L: External Code Sources. If not available, leave blank.
CDLPV024	Provider Medicaid Provider ID	varchar	30	Provider ID as assigned by Medicaid. If not available, leave blank.
CDLPV025	Provider Specialty 2	varchar	10	Report additional NUCC healthcare provider taxonomy code for second specialty. In addition to the taxonomy code listed in CDLPV021. If not available, leave blank. See Appendix L: External Code Source, National Uniform Claim Committee.
CDLPV026	Provider Specialty 3	varchar	10	Report third NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix L: External Code Source, National Uniform Claim Committee.

PROVIDER FILE				
CDLPV027	Provider Specialty 4	varchar	10	Report fourth NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix L: External Code Source, National Uniform Claim Committee.
CDLPV028	Provider Specialty-5	varchar	10	Report fifth NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix L: External Code Source, National Uniform Claim Committee.
CDLPVXXX	Un-assigned			Reserved for future use. Elements will only be added with review from states and payers.
CDLPV899	Record Type	char	2	Value=PV

G. Annual Payments File (AP)

This file accommodates data on contractually based non-claims payments made by a payer to a provider.

ANNUAL PAYMENTS FILE				
Element #	**Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLAP001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLAP002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLAP003	Reporting Period Start Date	integer	6	YYYYMM. Beginning of reporting period covered for contract performance.
CDLAP004	Reporting Period End Date	integer	6	YYYYMM. End of reporting period covered for contract performance.
CDLAP005	Contract Number	varchar	80	The unique number identifying a contract between the submitter and the billing provider for the reported payment model.
CDLAP006	Contract Type	char	1	Use this field to indicate whether the payments reported were administered as part of a medical benefits contract or a dental benefits contract. The only valid codes for this field are: M = Medical: Payments made under a medical benefits contract, including all payments made to providers for medical, pharmacy, and dental services incurred under medical stand-alone coverage. D = Dental: Payments made under a dental benefits contract; this should include only payments made to providers for members on dental stand-alone coverage.
CDLAP007	Billing Provider ID	varchar	35	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change.

ANNUAL PAYMENTS FILE

Element #	Element Name	Type	Max Length	Description/ Valid Values
CDLAP008	Billing Provider NPI	char	10	National Provider Identifier (NPI) for the billing provider as enumerated in the Center for Medicaid and Medicare Services National Plan & Provider Enumeration System (NPPES).
CDLAP009	Billing Provider Tax ID	char	9	Tax ID of the billing provider. Do not code punctuation.
CDLAP010	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.
CDLAP011	Billing Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.
CDLAP012	Payment Category	char	1	A = Population health and practice infrastructure payments B = Performance payments C = Payments with shared savings and recoupments D = Capitation and full risk payments E = Other non-claims payments X = Fee for service Z = Member count Select a corresponding Payment Subcategory based on the initial character in the Payment Category.

ANNUAL PAYMENTS FILE

Element #	Element Name	Type	Max Length	Description/ Valid Values
CDLAP013	Payment Subcategory	char	2	A1 = Care management/ care coordination/ population health/ medication reconciliation A2 = Primary care and behavioral health integration A3 = Social care integration A4 = Practice transformation payments A5 = EHR/HIT infrastructure payments B1 = Retrospective/prospective incentive payments: pay-for-reporting B2 = Retrospective/prospective incentive payments: pay-for-performance C1 = Procedure-related, episode-based payments with shared savings C2 = Procedure-related, episode-based payments with risk of recoupments C3 = Condition-related, episode-based payments with shared savings C4 = Condition-related, episode-based payments with risk of recoupments C5 = Risk for total cost of care (e.g., ACO) with shared savings C6 = Risk for total cost of care (e.g., ACO) with risk of recoupments D1 = Primary care capitation D2 = Professional capitation D3 = Facility capitation D4 = Behavioral health capitation D5 = Global capitation D6 = Payment to integrated, comprehensive payment and delivery systems X9 = Fee for service Z9 = Member count

ANNUAL PAYMENTS FILE				
Element #	**Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLAP014	Member Count	int	12	The total number of members enrolled during the reporting period. Report when Payment Category (CDLAP012) = 'B', 'C', 'D', or 'Z': 1. Category = 'B': Total number of members associated with the incentive payments. 2. Category = 'C': Total number of members associated with shared savings or recoupments. 3. Category = 'D': Total number of members associated with the capitated payments reported. 4. Category = 'Z': Total number of members enrolled (members for submitters entire book of business for the year). This record is not expected to have any associated dollar amounts reported.

ANNUAL PAYMENTS FILE

Element #	Element Name	Type	Max Length	Description/ Valid Values
CDLAP015	Member Months	int	12	Total number of members months during the reporting period, expressed in months of membership. Only report members for whom the data submitter is the primary payer. Report with Payment Category (CDLAP012) = 'B', 'D', or 'Z' or Payment Subcategory = 'C5' or 'C6': 1. Category = 'B': Total number of member months associated with the incentive payments. 2. Category = 'D': Total number of member months associated with the capitated payments reported. 3. Category = 'Z': Total number of months enrolled for members reported in Member Count (member months for submitters entire book of business for the year). This record is not expected to have any associated dollar amounts reported. 4. Subcategory = 'C5': Total number of member months associated with risk for total cost of care (e.g., ACO) with shared savings 5. Subcategory = 'C6': Total number of member months associated with risk for total cost of care (e.g., ACO) with risk of recoupments
CDLAP016	Total Amount Paid/Allowed	int	12	Total of all payments made to the billing provider during the Reporting/Performance Period. For non-fee for service payments, this is the amount paid to the provider by the insurer. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.

ANNUAL PAYMENTS FILE

Element #	Element Name	Type	Max Length	Description/ Valid Values
CDLAP017	Total Member Responsibility Amount	int	12	Total of all member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP018	Total Amount Paid for Primary Care	int	12	Total of all payments made to a billing provider for primary care services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000. If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP019	Total Amount Paid for Behavioral Health	int	12	Total of all payments made to a billing provider for behavioral health services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP899	Record Type	char	2	Value = AP

H. Pharmacy Rebates File (PR)

This file accommodates data on prescription drug rebate payments. "Pharmacy rebates" means payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system for drugs identified using the National Drug Code (NDC) labeler and product codes.

PHARMACY REBATE FILE

Element #	Element Name	Type	Max Length	Description/ Valid Values
CDLPR001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLPR002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLPR003	Reporting Period Start Date	integer	6	YYYYMM. Beginning of reporting period covered for contract performance.
CDLPR004	Reporting Period End Date	integer	6	YYYYMM. End of reporting period covered for contract performance.
CDLPR005	Drug Code - NDC Product Code	varchar	9	Report the National Drug Code (NDC) product code, which includes the first 8 or 9 digits and excludes the last one or two digits (package code) of the NDC. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. See Appendix J: External Code Source, United States Food and Drug Administration.
CDLPR006	Drug Manufacturer	varchar	50	Use this field to report the manufacturer of the drug.
CDLPR007	Drug Name	varchar	80	Use this field to report the text name of the drug.
CDLPR008	Brand/Generic Indicator	char	2	Indicates whether the drug itself is generic, not how the payer pays it. Valid codes are: 01=Branded drug 02=Generic drug.
CDLPR009	Prescription Count	int	12	Number of prescription fills for each drug. Includes original prescriptions and refills.

PHARMACY REBATE FILE

Element #	Element Name	Type	Max Length	Description/ Valid Values
CDLPR010	Member Count	int	12	Number of members filling a prescription during the reporting period.
CDLPR011	Total Paid Amount	int	12	Total of all payments made during the Reporting/Performance Period. Round to the nearest dollar (e.g., $1,000.25 converted to 1000. If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLPR012	Rebates Received	int	12	Report the total amount of the rebate received for the specified NDC code. Round to the nearest dollar (e.g., $1,000.25 converted to 1000. If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLPR899	Record Type	char	2	Value = PR

I. Capitations File (CF)

This file accommodates data on payments made by a payer to a provider for member-attributable services under a capitation arrangement.

CAPITATION FILE

Element #	Element Name	Type	Max Length	Description/ Valid Values
CDLCF001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLCF002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLCF003	Reporting Period Start Date	integer	6	YYYYMM. Beginning of reporting period covered for contract performance.
CDLCF004	Reporting Period End Date	integer	6	YYYYMM. End of reporting period covered for contract performance.
CDLCF005	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.
CDLCF006	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.
CDLCF007	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.
CDLCF008	Member Middle Initial	varchar	1	The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.

CAPITATION FILE

Element #	Element Name	Type	Max Length	Description/ Valid Values
CDLCF009	Member Sex	char	1	Sex of the member. M=Male; F=Female; U=UNKNOWN. Member sex represents biological or administrative sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values).
CDLCF010	Member Date of Birth	date	8	Date of birth of the member. If the member is the subscriber, report the subscriber's date of birth. YYYYMMDD.
CDLCF011	Member Social Security Number	char	9	The member's Social Security Number. If the member is the subscriber, report the subscriber's Social Security Number. Do not include dashes. Leave blank if not collected.
CDLCF012	Billing Provider ID	varchar	35	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change.
CDLCF013	Billing Provider NPI	char	10	National Provider Identifier (NPI) for the billing provider as enumerated in the Center for Medicaid and Medicare Services National Plan & Provider Enumeration System (NPPES).
CDLCF014	Billing Provider Tax ID	char	9	Tax ID of the billing provider. Do not code punctuation.
CDLCF015	Billing Provider Last Name or Organization	varchar	60	Full name of provider billing organization or last name of individual billing provider.
CDLCF016	Billing Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.

CAPITATION FILE

Element #	Element Name	Type	Max Length	Description/ Valid Values
CDLCF017	Insurance/ Product Category Code	char	2	See Appendix J: Insurance Type/Product Category for codes. Use the most granular choice available.
CDLCF018	Payment Subcategory	char	2	D1 = Primary care capitation D2 = Professional capitation D3 = Facility Capitation D4 = Behavioral health capitation D5 = Global capitation D6 = Payment to integrated, comprehensive payment and delivery systems
CDLCF019	Total Paid Amount	integer	12	Total of all payments made to a contractor during the Reporting/Performance Period. Round to the nearest dollar (e.g., $1,000.25 converted to 1000). This field may contain a negative value.
CDLCF899	Record Type	char	2	Value = CF

Appendix J. Insurance Type/ Product Code Values

APPENDIX J - INSURANCE TYPE/PRODUCT CODE This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-Fault Insurance including Insurance in which Auto Is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
17	Dental
18	Vision
19	Prescription Drugs (Commercial Coverage)
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Is Primary
AP	Auto Insurance Policy
C1	Other Commercial (Not Specified Elsewhere)
CO	Consolidated Omnibus Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits

APPENDIX J - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
E	Medicare – Point of Service (POS)
EP	Exclusive Provider Organization
FH	Federal Employees Health Benefits Program (HMO)
FP	Federal Employees Health Benefits Program (PPO)
FF	Family or Friends
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A (not to be used for commercial plans)
MB	Medicare Part B (not to be used for commercial plans)
MC	Medicaid
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B

APPENDIX J - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
MO	Medicare Advantage PPO
MP	Medicare Primary (not to be used for commercial plans)
MT	Medicaid CHIP
OT	Other
PE	Property Insurance – Personal
PL	Personal
PP	Personal Payment (Cash – No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance – Real
SP	Supplemental Policy
S1	Medicare Special Needs Plan – Chronic Condition
S2	Medicare Special Needs Plan - Institutionalized
S3	Medicare Special Needs Plan – Dual Eligible
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
TR	Tricare
U	Multiple Options Health Plan
VA	Veterans Administration Plan
WC	Workers' Compensation

APPENDIX J - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
WU	Wrap Up Policy
11	Other Non-Federal Programs
DM	Dental Maintenance Organization
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	CHAMPUS
CI	Commercial Insurance Company
LB	Liability
LM	Liability Medical
OF	Other Federal Program
TV	Title V
SL	Standalone limited (for example, vision only, hearing only)
ZZ	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)

Appendix K. Market Category Codes

APPENDIX K - MARKET CATEGORY CODES	
Code	**Description**
IND	Individuals (non-group)
FCH	Individuals on a franchise basis
GCV	Individuals as group conversion Policies
GS1	Employers having exactly 1 employee
GS2	Employers having 2 thru 9 employees
GS3	Employers having 10 thru 25 employees
GS4	Employers having 26 thru 50 employees
GLG1	Employers having 51 thru 100 employees
GLG2	Employers having 101 thru 250 employees
GLG3	Employers having 251 thru 500 employees
GLG4	Employers having more than 500 employees
GSA	Small employers through a qualified association trust
OTH	Other types of entities. Insurers using this market code shall obtain prior approval.

Appendix L. External Code Sources

APPENDIX L - EXTERNAL CODE SOURCES
Accredited Standards Committee (ASC) ASC X12 Directories SOURCE: PACDR Implementation Guides, ASC X12 005010 Standard AVAILABLE FROM: Data Interchange Standards Association, Inc. (DISA) 7600 Leesburg Pike Ste 430 Falls Church, VA 22043 http://store.x12.org/store Washington Publishing Company http://www.wpc-edi.com/reference/ ABSTRACT: The PACDR Implementation Guides contain the descriptions of data elements used to construct X12 segments. The PACDR Guides also contain code lists associated with these data elements.
American Dental Association (ADA) Current Dental Terminology (CDT) Codes SOURCE: Current Dental Terminology (CDT) Manual AVAILABLE FROM: American Dental Association 211 East Chicago Avenue Chicago, IL 60611-2678 ABSTRACT: The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

APPENDIX L - EXTERNAL CODE SOURCES

American Medical Association (AMA)
Current Procedural Terminology (CPT) Codes
SOURCE: Physicians' Current Procedural Terminology (CPT) Manual
AVAILABLE FROM:
American Medical Association
515 North State Street
Chicago, IL 60654
ABSTRACT: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

Centers for Disease Control and Prevention (CDC)
SOURCE: Race and Ethnicity Code Set
AVAILABLE FROM:
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329-4027
FILE: PH_RaceAndEthnicity_CDC_v1.2_Final.xlsx - Race and Ethnicity Download File (Full Code System, relationships, and concept and hierarchical codes) found in "CDC Race Category and Ethnicity Group" at https://phinvads.cdc.gov/vads/SearchVocab.action.
ABSTRACT: The race and ethnicity code set is used for coding the race and ethnicity of the member.

Centers for Medicare and Medicaid Services (CMS)
CMS Certification Numbers (CCN)
SOURCE: CMS Certification Numbers (CCN)
AVAILABLE FROM:
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r29soma.pdf
ABSTRACT: The place of service code identifies the location where the healthcare service was rendered.

APPENDIX L - EXTERNAL CODE SOURCES

Centers for Medicare and Medicaid Services
Healthcare Common Procedural Coding System (HCPCS)
SOURCE: Health Care Common Procedural Coding System
AVAILABLE FROM:
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
www.cms.gov/HCPCSReleaseCodeSets/
ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

Centers for Medicare and Medicaid Services
HHS Actuarial Value Calculator
SOURCE: Center for Consumer Information & Insurance Oversight
AVAILABLE FROM:
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html ABSTRACT: CCIIO publishes an AV calculator on an annual basis.

APPENDIX L - EXTERNAL CODE SOURCES

Centers for Medicare and Medicaid Services
Health Insurance Prospective Payment System (HIPPS)
SOURCE: Center for Medicare & Medicaid Services
AVAILABLE FROM:
Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
http://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
ABSTRACT: Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. For the payment systems that use HIPPS codes, clinical assessment data is the basic input used to determine which case-mix group applies to a particular patient. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group. For payment purposes, at least one HIPPS code is defined to represent each case-mix group. These HIPPS codes are reported on claims to insurers.

Centers for Medicare and Medicaid Services
National Provider Identifier (NPI)
SOURCE: National Plan and Provider Enumeration System (NPPES)
AVAILABLE FROM:
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
https://nppes.cms.hhs.gov/NPPES/Welcome.do
ABSTRACT: The Centers for Medicare and Medicaid Services developed the National Provider Identifier as the standard, unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

APPENDIX L - EXTERNAL CODE SOURCES

Centers for Medicare and Medicaid Services
Place of Service Codes for Professional Claims
SOURCE: Place of Service Codes for Professional Claims
AVAILABLE FROM:
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf
ABSTRACT: The place of service code identifies the location where the healthcare service was rendered.

ISO 3166 Maintenance Agency
Country Codes
SOURCE: ISO 3166 Maintenance Agency
AVAILABLE FROM:
ISO 3166 Maintenance Agency
c/o International Organization for Standardization
Chemin de Blandonnet 8
CP 401
1214 Vernier, Geneva Switzerland
Telephone: +41 22 749 01 11
e-mail: customerservice@iso.org
www.iso.org/iso/country_codes

APPENDIX L - EXTERNAL CODE SOURCES

ISO 639-3:2007 Language
Language
SOURCE: ISO 639 Maintenance Agency
AVAILABLE FROM:
International Organization for Standardization
ISO Central Secretariat
Chemin de Blandonnet 8
CP 401
1214 Vernier, Geneva, Switzerland
E-mail: central@iso.org
https://www.iso.org/standard/39534.html

National Association of Insurance Commissioners
NAIC Codes
SOURCE: National Association of Insurance Commissioners
AVAILABLE FROM:
NAIC Central Office
1100 Walnut Street Suite 1500
Kansas City, MO 64106
816.842.3600
http://www.naic.org/prod_serv/LOC-ZU-15-01.pdf, https://eapps.naic.org/cis/companySearch.do
ABSTRACT: NAIC maintains an identification code for each payer that is a 5-digit unique number assigned to an insurance entity by the NAIC. NAIC has developed a tool to look up the code and find the company, or look up the company to find the code:

APPENDIX L - EXTERNAL CODE SOURCES

National Council for Prescription Drug Programs (NCPDP)
National Association of Boards of Pharmacy Number
SOURCE: National Association of Boards of Pharmacy Database and Listings
AVAILABLE FROM:
www.ncpdp.org
National Council for Prescription Drug Programs
9240 East Raintree Drive
Scottsdale, AZ 85260-7518
ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy Number is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

National Council for Prescription Drug Programs
Uniform Healthcare Payer Data
SOURCE: NCPDP Uniform Healthcare Payer Data Standard Implementation Guide
AVAILABLE FROM:
National Council for Prescription Drug Programs
9240 East Raintree Drive
Scottsdale, AZ 85260
www.ncpdp.org
ABSTRACT: The Implementation Guide is intended to meet an industry need to supply detailed drug or utilization claim information from adjudicated claims that processors/payers or their clients report to States or their Agents.

APPENDIX L - EXTERNAL CODE SOURCES

National Uniform Billing Committee (NUBC)
NUBC Codes
SOURCE: National Uniform Billing Committee Official Data Specifications Manual
AVAILABLE FROM:
National Uniform Billing Committee American Hospital Association
155 N Wacker Drive
Chicago, IL 60606
www.nubc.org

National Uniform Claim Committee (NUCC)
Healthcare Provider Taxonomy Code Set
SOURCE: Washington Publishing Company
AVAILABLE FROM:
National Uniform Claim Committee
nuccinfo@nucc.org
http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

United States Food and Drug Administration (FDA)
National Drug Codes
SOURCE: National Drug Data File
AVAILABLE FROM:
U.S. Food and Drug Administration Center for Drug Evaluation and Research
Division of Data Management and Services
10903 New Hampshire Avenue
Silver Spring, MD 20993
www.fda.gov or http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm

United States Census Bureau
2010 FIPS Codes for Counties and County Equivalent Entities
SOURCE: United States Census Bureau, Geography
https://www.census.gov/library/reference/code-lists/ansi.html
AVAILABLE FROM:
United States Census Bureau, Geography
https://www.census.gov/geo/reference/codes/cou.html

APPENDIX L - EXTERNAL CODE SOURCES

United States Postal Service (USPS)
States and Outlying Areas of the U.S. ZIP Code
SOURCE: United States Postal Service
AVAILABLE FROM:
U.S. Postal Service
National Information Data Center
P.O. Box 9408
Gaithersburg, MD 20898-9408
https://www.usps.com
ABSTRACT: Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two right-most digits identify a local delivery area. In the 9-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

World Health Organization (WHO)
International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure and Diagnosis
SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
AVAILABLE FROM:
WHO Publications Center AUS
49 Sheridan Avenue
Albany, NY 12210
http://www.cdc.gov/nchs/icd/icd9cm.htm
ABSTRACT: The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and procedures.

APPENDIX L - EXTERNAL CODE SOURCES

World Health Organization
International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)
SOURCE: International Classification of Diseases, 10th Revision, (ICD-10-CM/PCS)
AVAILABLE FROM:
WHO Publications Center AUS
49 Sheridan Avenue
Albany, NY 12210
www.cdc.gov/nchs/icd/icd10cm.htm#9update
ABSTRACT: The International Classification of Diseases, 10th Revision, is used to report medical diagnosis in all U.S. health care settings after October 1, 2015.