**90-590 MAINE HEALTH DATA ORGANIZATION**

**Chapter 243: UNIFORM REPORTING SYSTEM FOR HEALTH CARE CLAIMS DATA SETS**

**SUMMARY**: This Chapter contains the provisions for filing health care claims data sets from all third-party payers, third-party administrators, Medicare health plan sponsors and pharmacy benefits managers.

The provisions include:

Identification of the organizations required to report;

Establishment of requirements for the content, format, method, and time frame for filing health care claims data;

Establishment of standards for the data reported; and

Compliance provisions.

**1. Definitions**

Unless the context indicates otherwise, the following words and phrases shall have the following meanings:

A. **Billing Provider**. “Billing provider” means a provider or other entity that submits claims to health care claims processors for health care services directly performed or provided to a subscriber or member by a service provider.

B. **Capitated Services**. “Capitated services” means services rendered by a provider through a contract where payments are based upon a fixed dollar amount for each member monthly.

C. **Carrier**. "Carrier" means an insurance company licensed in accordance with 24-A M.R.S., including a health maintenance organization, a multiple employer welfare arrangement licensed pursuant to Title 24-A, chapter 81, a preferred provider organization, a fraternal benefit society, or a nonprofit hospital or medical service organization or health plan licensed pursuant to 24 M.R.S. An employer exempted from the applicability of 24-A M.R.S., chapter 56-A under the federal *Employee Retirement Income Security Act of 1974*, 29 *United States Code*, Sections 1001 to 1461 (1988) (“ERISA”) is not considered a carrier.

D. **Co-Insurance**. “Co-insurance” means the dollar amount a member pays as a pre-determined percentage of the cost of a covered service after the deductible has been paid.

E. **Co-Payment**. “Co-payment” means the fixed dollar amount a member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

F. **Deductible**. "Deductible" means the total dollar amount a member pays towards the cost of covered services over an established period before any payments are made by the contracted third-party payer.

G. **Dental Claims File**. “Dental claims file” means a data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge/payment information, and current dental terminology codes from all non-denied adjudicated claims for each billed service.

H. **Designee**. "Designee" means an entity with which the MHDO has entered into an arrangement under which the entity performs data collection, validation and management functions for the MHDO and is strictly prohibited from releasing information obtained in such a capacity.

I. **Health Care Claims Processor**. “Health care claims processor” means a third-party payer, third-party administrator, Medicare health plan sponsor, or pharmacy benefits manager.

J. **HICN**. “HICN” means the Center for Medicare and Medicaid Services Health Insurance Claim Number.

K. **Hospital**. "Hospital" means any acute care institution required to be licensed pursuant to 22 M.R.S., chapter 405.

L. **MBI**. “MBI” means the Center for Medicare and Medicaid Services Medicare Beneficiary Identifier.

M. **Medical Claims File**. “Medical claims file” means a data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge/payment information, and clinical diagnosis/procedure codes from all non-denied adjudicated claims for each billed service.

N. **Medicare Health Plan Sponsor**. “Medicare health plan sponsor” means a health insurance carrier or other private company authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services to administer Medicare Part C and Part D benefits under a health plan or prescription drug plan.

O. **Member**. “Member” includes the subscriber and any spouse or dependent who is covered by the subscriber’s policy.

P. **Member Eligibility File**. “Member eligibility file” means a data file composed of demographic information for each individual member eligible for medical, pharmacy, or dental insurance benefits for one or more days of coverage any time during the reporting month.

Q. **MHDO**. "MHDO" means the Maine Health Data Organization.

R. **M.R.S.** “M.R.S.” means *Maine Revised Statutes*.

S. **Non-hospital Provider**. "Non-hospital provider" means any provider of health care services other than a hospital.

T. **Pharmacy**. “Pharmacy” means a drug outlet licensed under 32 M.R.S., chapter 117.

U. **Pharmacy Benefits Manager**. "Pharmacy benefits manager" means an entity that performs pharmacy benefits management as defined in 24-A M.R.S. §4347, sub-section 17.

V. **Pharmacy Claims File**. “Pharmacy claims file” means a data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge/payment information, and national drug codes from all non-denied adjudicated claims for each prescription filled.

W. **Plan Sponsor**. “Plan sponsor” means any person, other than an insurer, who establishes or maintains a plan covering residents of the State of Maine, including, but not limited to, plans established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, or the association, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the plan.

X. **Prepaid Amount**. “Prepaid amount” means the fee for service equivalent that would have been paid by the health care claims processor for a specific service if the service had not been capitated.

Y. Provider. "Provider" means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.

Z. **Service Provider**. “Service provider” means the provider who directly performed or provided a health care service to a subscriber or member.

AA. **Subscriber**. “Subscriber” is the insured individual.

BB. **Third-party Administrator**. “Third-party administrator” means any person licensed by the Maine Bureau of Insurance under 24-A M.R.S., chapter 18 who, on behalf of a plan sponsor, health care service plan, nonprofit hospital or medical service organization, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on residents of this State.

CC. Third-party Payer. "Third-party payer" means a state agency that pays for health care services or a health insurer, carrier, including a carrier that provides only administrative services for plan sponsors, nonprofit hospital, medical services organization, or managed care organization licensed in the State.

**2. Health Care Claims Data Set Filing Description**

Health care claims processors shall submit to the MHDO or its designee a completed health care claims data set for all members who are Maine residents in accordance with the requirements of this section. Each health care claims processor is also responsible for the submission of all health care claims processed by any sub-contractor on its behalf. The health care claims data set shall include, where applicable, a member eligibility file containing records associated with each of the claims files reported: a medical claims file, a pharmacy claims file, and/or a dental claims file. The data set shall also include supporting definition files for payer specific provider specialty codes. Third-party administrators and carriers acting as third-party administrators for self-funded employee benefit plans regulated by ERISA are not required to submit data for members in such plans.

A. **General Requirements**

(1) **Adjustment Records**. Adjustment records shall be reported with the appropriate positive or negative fields with the medical, pharmacy, and dental claims file submissions. Negative values shall contain the negative sign before the value. No sign shall appear before a positive value.

(2) **Capitated Service Claims**. Claims for capitated services shall be reported with all medical, pharmacy, and dental claims file submissions.

(3) **Claims Records**. Records for the medical, pharmacy, and dental claims file submissions shall be reported at the visit, service, or prescription level. The submission of the medical, pharmacy, and dental claims is based upon the paid dates and not upon the dates of service associated with the claims.

(4) **Codes**

(a) **Code Sources**. Unless otherwise specified, the code sources listed and described in Appendix A are to be utilized in association with the member eligibility file and medical, pharmacy, and dental claims file submissions.

(b) **Specific/Unique Coding**. Except for provider, provider specialty, and individual, non-bundled procedure/diagnosis codes, specific or unique coding systems shall not be permitted as part of the health care claims data set submission.

(5) **Co-Insurance/Co-Payment**. Co-insurance and co-payment are to be reported in two separate fields in the medical, pharmacy, and dental claims file submissions.

(6) **Coordination of Benefits Claims**. Claims where multiple parties have financial responsibility shall be included with all medical, pharmacy, and dental claims file submissions.

(7) **Denied Claims**. Denied claims shall be excluded from all medical, pharmacy, and dental claims file submissions. When a claim contains both approved and denied service lines, only the approved service lines shall be included as part of the health care claims data set submittal.

(8) **Eligibility Records**. Records for the member eligibility file submission shall be reported at the individual member level with one record submitted for each claim type if the product codes are different. If a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted.

(9) **Exclusions**

(a) **Filing**. Health care claims processors that have less than $2,000,000 per calendar year of adjusted premiums or claims processed, for premiums or claims subject to required reporting, are excluded from filing health care claim data sets and from the annual registration requirements of Section 3(A).

(b) **Medical Claims File Exclusions**. All claims related to health care policies issued for specific disease, accident, injury, hospital indemnity, disability, long-term care, student comprehensive health, or vision coverage of durable medical equipment are to be excluded from the medical claims file submission. Claims related to Medicare supplemental, Tricare supplemental, or other supplemental health insurance policies are to be excluded if the claims are not considered to be primary. If the policies cover health care services entirely excluded by the Medicare, Tricare, or other program, the claims must be submitted. Claims for dental services containing current dental terminology codes are to be excluded from the medical claims file.

(c) **Member Eligibility File Exclusions**. Members without medical, pharmacy, and/or dental coverage during the month reported shall be excluded.

(d) **Pharmacy Claims File Exclusions**. Pharmacy services claims generated from non-retail pharmacies that do not contain national drug codes are part of the medical claims file and not the pharmacy claims file.

(10) **File Format**. Each data file submission shall be an encrypted (AES-256) ASCII file, variable field length, and asterisk delimited.

(11) **Header and Trailer Records**. Each member eligibility file and each medical, pharmacy, and dental claims file submission shall contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last. The header and trailer record formats are described in Appendices B-1 and B-2.

(12) **Non-Duplicated Claims.** A carrier or health care claims processor and any contracted entity acting on its behalf shall use best efforts to ensure that duplicate claims are not submitted to the MHDO or its designee.

(13) **Prepaid Amount**. Any prepaid amounts are to be reported in a separate field in the medical, pharmacy, and dental claims file submissions.

(14) **Subscriber or Member Identification**

(a) **Social Security Numbers**. Health care claims processors shall assign to each of their members a unique identification code that is the member’s social security number. If a health care claims processor does not collect the social security numbers for all members, the health care claims processor shall use the number of the subscriber and then assign a discrete two-digit suffix for each member under the subscriber’s contract.

(b) **Contract Numbers**. If the subscriber’s social security number is not collected by the health care claims processor, the subscriber’s certificate or contract number shall be used in its place. The discrete two-digit suffix shall also be used with the certificate or contract number.

The unique member identification code assigned by each health care claims processor shall remain with each subscriber or member for the entire period of coverage for that individual.

(c) **Names**. Health care claims processors shall submit the complete names of all subscribers and members.

                (d) **Consistent, Inter-file Identifiers.** A carrier or health care claims processor and any contracted entity acting on its behalf shall ensure that member and subscriber identifiers for the same individuals are unique and consistent across medical claims, pharmacy claims and member eligibility files.

B. **Detailed File Specifications**

(1) **Filled Fields**. All required fields shall be filled where applicable. Non-requiredtext and number fields shall be left blank when unavailable.

(2) **Position**. All text fields are to be left justified. All numeric fields are to be right justified.

(3) **Signs**. Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all numeric fields. Signed over punch characters are not to be utilized.

(4) **Individual Elements and Mapping**. Individual data elements, data types, field lengths, field description/code assignments, and mapping locators (UB-04, CMS 1500, ANSI X12N 270/271, 835, 837) for each file type are presented in the following appendices:

(a) (i) Member Eligibility File Specifications – Appendix C-1

(ii) Member Eligibility File Mapping to National Standard Formats – Appendix C-2

(b) (i) Medical Claims File Specifications – Appendix D-1

(ii) Medical Claims File Mapping to National Standard Formats – Appendix D-2

(c) (i) Pharmacy Claims File Specifications – Appendix E-1

(ii) Pharmacy Claims File Mapping to National Standard Formats – Appendix E-2

(d) (i) Dental Claims File Specifications – Appendix F-1

(ii) Dental Claims File Mapping to National Standard Formats – Appendix F-2

**3. Submission Requirements**

A. **Registration/Contact and Enrollment Update**. Each health care claims processor not excluded from submitting claims data under Section 2 or 2(A)(9)(a) shall complete a registration survey or update an existing one at <https://mhdo.maine.gov/portal> by February 28th of each year. It is the responsibility of the health care claims processor to amend, as needed, all company, contact and enrollment information.

B. **File Organization**. The member eligibility file, medical claims file, pharmacy claims file, and the dental claims file are to be submitted to the MHDO or its designee as separate ASCII files. Each record shall be terminated with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).

C. **Filing Method**. Data files must be submitted to the MHDO’s Data Warehouse Portal via secure FTP or secure web upload interface. E-mail attachments shall not be accepted.

D. **Testing of Files**. Within one hundred and eighty days of the adoption of any changes to the data element content of the files as described in Section 2 and at least sixty days prior to the initial submission of the files or whenever the data element content of the files as described in Section 2 is subsequently altered, each health care claims processor shall submit to the MHDO or its designee a data set for comparison to the standards listed in Section 4. The size, based upon a calendar period of one month or one quarter, of the data files submitted shall correspond to the filing period established for each health care claims processor under subsection F of this Section.

E. **Rejection of Files**. Failure to conform to the requirements subsections   
A, B, or C of this Section shall result in the rejection of the applicable data file(s). All rejected files must be resubmitted in the appropriate, corrected form to the MHDO or its designee within 15 days.

F. **Filing Periods**. The filing period for each applicable claims data file listed in Section 2 shall be determined by the minimum monthly total of Maine-resident members for whom claims are being paid by each health care claims processor. The data files are to be submitted in accordance with the following schedule:

|  |  |  |
| --- | --- | --- |
| **Total # of Members** | **Filing Period** | **Filing Schedule** |
| ≥ 2,000 | monthly | prior to the end of the month following the month in which claims were paid |
| < 2,000 | quarterly | prior to April 30, July 31, October 31, January 31 for each preceding calendar quarter in which claims were paid |
|  |  |  |

If the data files submitted by an individual health care claims processor support or are related to the files submitted by another health care claims processor, the MHDO shall determine a filing period that is consistent for all parties involved.

G. **Replacement of Data Files**. No health care claims processor may replace a complete data file submission more than one year after the end of the month in which the file was submitted unless it can establish exceptional circumstances for the replacement. Any replacements after this period must be approved by the MHDO. Individual adjustment records may be submitted with any monthly data file submission.

H. **Run-Out Period**. Health care claims processors shall submit medical, pharmacy, and/or dental claims files for a six-month period following the termination of coverage date for all members who are Maine residents.

**4. Standards for Data; Notification; Response**

A. **Standards**. The MHDO or its designee shall evaluate each member eligibility file, medical claims file, pharmacy claims file, and dental claims file submission in accordance with the following standards:

(1) The applicable code for each data element identified in Appendices C-1, D-1, E-1, and F-1 shall be included within eligible values for the element;

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

(3) Member sex, diagnosis and procedure codes, and date of birth and all other date fields shall be consistent within an individual record; and

(4) Member identifiers shall be consistent across files.

B. **Notification**. Upon completion of this evaluation, the MHDO or its designee will promptly notify each health care claims processor whose data submissions do not satisfy the standards for any filing period. This notification will identify the specific file and the data elements within them that do not satisfy the standards.

C. **Response**. Each health care claims processor notified under subsection 4. B, will respond within 60 days of the notification by making the changes necessary in order to satisfy the standards.

**5. Voluntary File Submissions**

Any self-funded employee benefit plan regulated by ERISA may voluntarily submit completed healthcare data sets for Maine residents. The MHDO shall collect such data sets in accordance with the provisions of this chapter for uniform reporting system for health care claims data sets. Any such data shall be subject to the same laws and regulations as other MHDO data.

**6. Public Access**

Information collected, processed and/or analyzed under this rule shall be subject to release to the public or retained as confidential information in accordance with 22 M.R.S. Chapter 1683 and *Code of Maine Rules* 90-590, Chapter 120, unless prohibited by state or federal law.

**7. Extensions or Waivers to Data Submission Requirements**

If a health care claims processor due to circumstances beyond its control is temporarily unable to meet the terms and conditions of this Chapter, a written request must be made to the Compliance Officer of the MHDO as soon as it is practicable after the health care claims processor has determined that an extension or waiver is required. The written request shall include: the specific requirement to be extended or waived; an explanation of the cause; the methodology proposed to eliminate the necessity of the extension or waiver; and the time frame required to come into compliance. If the Compliance Officer does not approve the requested extension or waiver, the health claims processor making the request may submit a written request appealing the decision to the MHDO Board. The appeal shall be heard by the MHDO Board at the next regularly scheduled meeting following receipt of the request at the MHDO.

**8. Compliance**

The failure to file, report, or correct health care claims data sets when required in accordance with the provisions of this Chapter may be considered a violation under 22 M.R.S. Sec. 8705-A and Code of Maine Rules 90-590, Chapter 100: *Enforcement Procedures*.

STATUTORY AUTHORITY: 22 M.R.S. §§ 8703(1), 8704(4), 8708(6-A) and 8712(2)

EFFECTIVE DATE:

July 29, 2002

AMENDED:

June 2, 2003 – filing 2003-173

NON-SUBSTANTIVE CORRECTIONS:

September 8, 2003 – formatting only

AMENDED:

February 28, 2006 – filing 2006-89

CORRECTION:

May 24, 2006 – restored item in Appendix C-1 under ME012, “34 Other Adult”

AMENDED:

April 15, 2009 – filing 2009-157

October 31, 2012 – filing 2012-295

May 27, 2014 – filing 2014-100

October 6, 2015 – filing 2015-183

March 13, 2017 – filing 2017-045

June 27, 2018 – filing 2018-111

December 22, 2019 – filing 2019-246

October 12, 2020 – filing 2020-217

**(with references to specific MHDO data elements by file type)**

**American Dental Association**

**Current Dental Terminology (CDT) Codes**

**(MHDO Data Element: DC032, MC055)**

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.

**American Medical Association**

**Current Procedural Terminology (CPT) Codes**

**(MHDO Data Element: MC055)**

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.

**Accredited Standards Committee (ASC)**

**ASC X12 Directories**

**(MHDO Data Elements: DC003, DC011, DC012, DC021, DC031, MC003, MC011, MC012, MC027, MC038, ME003, ME007, ME012, ME013, PC003, PC025)**

SOURCE: Complete ASC X12 005010 Standard

AVAILABLE FROM:

https://www.nex12.org/

Data Interchange Standards Association, Inc. (DISA)

7600 Leesburg Pike Ste 430

Falls Church, VA 22043

ABSTRACT: The complete standard includes design rules and guidelines, control standards, transaction set tables, data element dictionary, segment directory and code sources. The data element dictionary contains the format and descriptions of data ele­ments used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

**Canada Post**

**Canadian Provinces**

**(MHDO Data Elements: DC015, DC028, DC049, DC056, MC015, MC083, MC090, ME016, PC015, PC023)**

**Cities and ZIP Code**

**(MHDO Data Elements: DC014, DC016, DC027, DC029, DC048, DC050, DC055, DC057, MC014, MC016, MC082, MC084, MC089, MC091, ME015, ME017, PC014, PC016, PC022, PC024)**

SOURCE : Canada Post

AVAILABLE FROM :

[http://www.canadapost.ca/](http://www.canadapost.ca/%20)

**Centers for Disease Control and Prevention**

**HL7/CDC Race and Ethnicity Code Set**

**(MHDO Data Element: ME021, ME022, ME023, ME024, ME025, ME026, ME027)**

SOURCE: Race and Ethnicity Code Set

AVAILABLE FROM:

<http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf>

Centers for Disease Control and Prevention

1600 Clifton Road

Atlanta, GA 30329-4027

ABSTRACT: The race and ethnicity code set to be used for coding the race and ethnicity of members.

**Centers for Medicare and Medicaid Services**

**Health Care Common Procedural Coding System**

**(MHDO Data Element: MC055)**

SOURCE: Health Care Common Procedural Coding System

AVAILABLE FROM :

[www.cms.gov/HCPCSReleaseCodeSets/](http://www.cms.gov/HCPCSReleaseCodeSets/)

Centers for Medicare and Medicaid Services

7500 Security Boulevard

Baltimore, MD 21244‑1850

ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

**Health Insurance Prospective Payment System (HIPPS)**

**(MHDO Data Element: MC055)**

SOURCE: Center for Medicare & Medicaid Services

AVAILABLE FROM:

<http://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html>

Center for Medicare and Medicaid Services

7500 Security Boulevard

Baltimore, MD 21244

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.

**Medical Severity Diagnosis Related Group (MS-DRG) / Inpatient Prospective Payment System (IPPS)**

**(MHDO Data Element: MC071)**

SOURCE: Inpatient Prospective Payment System (IPPS)

AVAILABLE FROM:

[http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteinptPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteinpatientPPS/index.html)

Inpatient Prospective Payment System (IPPS), [List of final MS-DRGs](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html?DLPage=1&DLSort=0&DLSortDir=ascending) (Table 5)

Center for Medicare and Medicaid Services

7500 Security Boulevard

Baltimore, MD 21244

ABSTRACT: Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

**National Provider Identifier**

**(MHDO Data Elements: DC020, DC043, MC026, MC077, MC086, MC108, MC115, MC121, PC021, PC048)**

SOURCE: National Provider System

AVAILABLE FROM:

Centers for Medicare and Medicaid Services

7500 Security Boulevard

Baltimore, MD 21244-1850

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.

**Pass Through Payment Status and New Technology Ambulatory Payment Classification (APC) / Outpatient Prospective Payment System (OPPS)**

**(MHDO Data Element: MC073)**

SOURCE: Outpatient Prospective Payment System (OPPS), Addendum A

AVAILABLE FROM:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment>

Outpatient Prospective Payment System (OPPS), Addendum A

Center for Medicare and Medicaid Services

7500 Security Boulevard

Baltimore, MD 21244

ABSTRACT: The APC is the unit of payment under the Outpatient Prospective Payment System (OPPS), Individual services identified in the Healthcare Common Procedure Code System (HCPCS) are assigned codes based on similar clinical characteristics and similar costs.

**Place of Service Codes for Professional Claims**

**(MHDO Data Element: DC030, MC037)**

SOURCE: Place of Service Codes for Professional Claims

AVAILABLE FROM :

<https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set>

Centers for Medicare and Medicaid Services

7500 Security Boulevard

Baltimore, MD 21244‑1850

ABSTRACT: The place of service code identifies the location where the healthcare service was rendered.

**International Country Codes**

**(MHDO Data Elements: ME109, MC093, MC094, MC329, PC024A, PC109, DC109)**

SOURCE: [www.nationsonline.org/oneworld/country\_code\_list.htm](http://www.nationsonline.org/oneworld/country_code_list.htm)

ABSTRACT: The ISO country codes are internationally recognized codes that designate each country and most of the dependent areas with a two- or three-letter combination or a numeric code.

**National Council for Prescription Drug Programs**

**National Association of Boards of Pharmacy Number**

**(MHDO Data Element: PC018)**

SOURCE: National Association of Boards of Pharmacy Database and Listings

AVAILABLE FROM:

[www.ncpdp.org](http://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 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.

**Uniform Healthcare Payer Data**

**(MHDO Data Elements: PC011, PC012, PC030)**

SOURCE: NCPDP Uniform Healthcare Payer Data Standard Implementation Guide

AVAILABLE FROM:

[www.ncpdp.org](http://www.ncpdp.org)

National Council for Prescription Drug Programs

9240 East Raintree Drive

Scottsdale, AZ 85260

ABSTRACT: This standard 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.

**National Uniform Billing Committee (NUBC)**

**NUBC Codes**

**(MHDO Data Elements: MC020, MC021, MC023, MC036, MC054, MC201, MC207, MC209, MC211, MC213, MC215, MC217, MC219, MC221, MC223, MC225, MC227, MC229, MC231, MC233, MC235, MC237, MC239, MC241, MC243, MC245, MC247, MC249, MC251, MC255, MC257, MC259, MC261, MC263, MC265, MC267, MC269, MC271, MC273, MC275, MC277, MC279, MC281, MC283, MC285, MC287, MC289, MC291, MC293, MC295, MC297, MC299, MC301)**

SOURCE: National Uniform Billing Committee Official Data Specifications Manual

AVAILABLE FROM:

National UniformBilling Committee

American Hospital Association

155 N Wacker Drive

Chicago, IL 60606

ABSTRACT: This serves as the official source of information for institutional health care billing. It contains all billing conventions and codes, including form locators, data element descriptions, definitions, reporting requirements, field attributes, approval and effective dates, and revenue, condition, occurrence, and value codes.

**National Uniform Claim Committee**

**Healthcare Provider Taxonomy Code Set**

**(MHDO Data Element: DC026, MC032, MC113)**

SOURCE: Washington Publishing Company

MAINTAINED BY: National Uniform Claim Committee

<https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/taxonomy.html>

AVAILABLE FROM: Washington Publishing Company

[www.wpc-edi.com/products/code-lists/](http://www.wpc-edi.com/products/code-lists/)

ABSTRACT: The Healthcare Provider Taxonomy Code Set is a hierarchical code set that consists of codes, descriptions, and definitions.  Healthcare Provider Taxonomy Codes are designed to categorize the type, classification, and/or specialization of health care providers.  The Code Set consists of two sections:  Individuals and Groups of Individuals, and Non-Individual.

**United States Food and Drug Administration**

**National Drug Codes**

**(MHDO Data Element: PC026, MC075)**

SOURCE: National Drug Data File

AVAILABLE FROM:

[www.fda.gov](http://www.fda.gov) or <http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm>

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

ABSTRACT: The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

**United States Postal Service**

**States and Outlying Areas of the U.S.**

**(MHDO Data Elements: DC015, DC028, DC049, DC056, MC015, MC083, MC090, ME016, PC015, PC023)**

**ZIP Code**

**(MHDO Data Elements: DC014, DC016, DC027, DC029, DC048, DC050, DC055, DC057, MC014, MC016, MC082, MC084, MC089, MC091, ME015, ME017, PC014, PC016, PC022, PC024)**

SOURCE : United States Postal Service

AVAILABLE FROM :

<https://www.usps.com>

U.S. Postal Service

National Information Data Center

P.O. Box 9408

Gaithersburg, MD 20898-9408

Or

<https://ribbs.usps.gov/index.cfm?page=address_manage_quality>

Address Information Systems Products

National Customer Support Center

U.S. Postal Service

6060 Primacy Pkwy Ste 231

Memphis, TN 38119-5772

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**

**(MHDO Data Elements: MC039, MC040, MC041, MC042, MC043, MC044, MC045, MC046, MC047, MC048, MC049, MC050, MC051, MC052, MC053, MC058)**

SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD‑9-CM)

AVAILABLE FROM:

<http://www.cdc.gov/nchs/icd/icd9cm.htm>

WHO Publications Center AUS

49 Sheridan Avenue

Albany, NY 12210

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 operations.

**International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)**

**(MHDO Data Elements: MC200, MC202, MC203, MC204, MC205, MC206, MC208, MC210, MC212, MC214, MC216, MC218, MC220, MC222, MC224, MC226, MC228, MC230, MC232, MC234, MC236, MC238, MC240, MC242, MC244. MC246, MC248, MC250, MC252, MC254, MC256, MC258, MC260, MC262, MC264, MC266, MC268, MC270, MC272, MC274, MC276, MC278, MC280, MC282, MC284, MC286, MC288, MC290, MC292, MC294, MC296, MC298, MC300, MC302, MC303, MC304, MC305, MC306, MC307, MC308, MC309, MC310, MC311, MC312, MC313, MC314, MC315, MC316, MC317, MC318, MC319, MC320, MC321, MC322, MC323, MC324, MC325, MC326**

SOURCE: International Classification of Diseases, 10th Revision, (ICD‑10-CM/PCS)

AVAILABLE FROM:

[www.cdc.gov/nchs/icd/icd10cm.htm#9update](http://www.cdc.gov/nchs/icd/icd10cm.htm#9update)

WHO Publications Center AUS

49 Sheridan Avenue

Albany, NY 12210

ABSTRACT: The International Classification of Diseases, 10th Revision, is used to report medical diagnosis and inpatient procedures. ICD-10-CM is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar. ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10­PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding. The transition to ICD-10 is occurring because ICD-9 produces limited data about patients’ medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Data Element** |  | Date |  | **Maximum** |  |
| **#** | **Data Element Name** | **Effective** | **Type** | **Length** | **Description/Codes/Sources** |
|  |  |  |  |  |  |
| **HD001** | **Record Type** | 1/1/2003 | Text | 2 | HD |
|  |  |  |  |  |  |
| **HD002** | **Submitter** | 1/1/2003 | Text | 8 | MHDO-assigned identifier of payer submitting claims data. Do not leave blank. |
|  |  |  |  |  |  |
| **HD003** | **Payer** | 7/1/2012 | Text | 8 | MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage |
|  |  |  |  |  |  |
| **HD004** | **Type of File** | 1/1/2003 | Text | 2 | DC Dental Claims |
|  |  |  |  |  | MC Medical Claims |
|  |  |  |  |  | ME Member Eligibility |
|  |  |  |  |  | PC Pharmacy Claims |
|  |  |  |  |  |  |
| **HD005** | **Period Beginning Date** | 1/1/2003 | Text | 6 | CCYYMM |
|  |  |  |  |  | Beginning of paid period for Claims |
|  |  |  |  |  | Beginning of month covered for Eligibility |
|  |  |  |  |  |  |
| **HD006** | **Period Ending Date** | 1/1/2003 | Text | 6 | CCYYMM |
|  |  |  |  |  | End of paid period for Claims |
|  |  |  |  |  | End of month covered for Eligibility |
|  |  |  |  |  |  |
| **HD007** | **Record Count** | 1/1/2003 | Number | 10 | Total number of records submitted in this file |
|  |  |  |  |  | Exclude header and trailer record in count |
|  |  |  |  |  |  |
| **HD008** | **Comments** | 1/1/2003 | Text | 80 | Submitter may use to document this submission by assigning a filename,  system source, etc. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Data Element** |  | Date |  | **Maximum** |  |
| **#** | **Data Element Name** | **Effective** | **Type** | **Length** | **Description/Codes/Sources** |
|  |  |  |  |  |  |
| **TR001** | **Record Type** | 1/1/2003 | Text | 2 | TR |
|  |  |  |  |  |  |
| **TR002** | **Submitter** | 1/1/2003 | Text | 8 | MHDO-assigned identifier of payer submitting claims data. Do not leave blank. |
|  |  |  |  |  |  |
| **TR003** | **Payer** | 7/1/2012 | Text | 8 | MHDO-assigned code of the insurer/ underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage |
|  |  |  |  |  |  |
| **TR004** | **Type of File** | 1/1/2003 | Text | 2 | DC Dental Claims |
|  |  |  |  |  | MC Medical Claims |
|  |  |  |  |  | ME Member Eligibility |
|  |  |  |  |  | PC Pharmacy Claims |
|  |  |  |  |  |  |
| **TR005** | **Period Beginning Date** | 1/1/2003 | Text | 6 | CCYYMM |
|  |  |  |  |  | Beginning of paid period for Claims |
|  |  |  |  |  | Beginning of month covered for Eligibility |
|  |  |  |  |  |  |
| **TR006** | **Period Ending Date** | 1/1/2003 | Text | 6 | CCYYMM |
|  |  |  |  |  | End of paid period for Claims |
|  |  |  |  |  | End of month covered for Eligibility |
|  |  |  |  |  |  |
| **TR007** | **Date Processed** | 1/1/2003 | Text | 8 | CCYYMMDD |
|  |  |  |  |  | Date file was created |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Data Element** |  | Date |  | **Maximum** |  |
| **#** | **Data Element Name** | **Effective** | **Type** | **Length** | **Description/Codes/Sources** |
|  |  |  |  |  |  |
| **ME001** | **Submitter** | 1/1/2003 | Text | 8 | MHDO-assigned identifier of payer submitting claims data. Do not leave blank. |
|  |  |  |  |  |  |
| **ME002** | **Payer** | 7/1/2012 | Text | 8 | MHDO-assigned code of the insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Do not leave blank. |
|  |  |  |  |  |  |
| **ME003** | **Insurance Type/Product Code** | 1/1/2003 | Text | 2 | Code identifying the type of insurance policy within a specific insurance program. Refer to Appendix A  HN Medicare Part C  MD Medicare Part D |
|  |  |  |  |  |  |
| **ME004** | **Year** | 1/1/2003 | Number | 4 | Year for which eligibility is reported in this submission |
|  |  |  |  |  |  |
| **ME005** | **Month** | 1/1/2003 | Text | 2 | Month for which eligibility is reported in this submission |
|  |  |  |  |  |  |
| **ME006** | **Insured Group or Policy Number** | 1/1/2003 | Text | 30 | Group or policy number – not the number that uniquely identifies the subscriber |
|  |  |  |  |  |  |
| **ME007** | **Coverage Level Code** | 1/1/2003 | Text | 3 | Benefit coverage level  Refer to Appendix A |
|  |  |  |  |  |  |
| **ME008** | **Subscriber Social Security Number** | 1/1/2003 | Text | 9 | Subscriber’s social security number  Leave blank if unavailable |
|  |  |  |  |  |  |
| **ME009** | **Plan Specific Contract Number** | 1/1/2003 | Text | 80 | Plan assigned subscriber’s contract number  Leave blank if contract number = subscriber’s social security number |
|  |  |  |  |  |  |
| **ME010** | **Member Suffix or Sequence Number** | 1/1/2003 | Text | 20 | Unique number of the member within the contract |
|  |  |  |  |  |  |
| **ME011** | **Member Identification Code** | 1/1/2003 | Text | 50 | Member’s social security number  Leave blank if unavailable |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **ME012** | **Individual Relationship Code** | 1/1/2003 | Text | 2 | Member’s relationship to insured  Refer to Appendix A |
|  |  |  |  |  |  |
| **ME013** | **Member Gender** | 1/1/2003 | Text | 1 | Refer to Appendix A |
|  |  |  |  |  |  |
| **ME014** | **Member Date of Birth** | 1/1/2003 | Text | 8 | CCYYMMDD |
|  |  |  |  |  |  |
| **ME015** | **Member City Name** | 4/1/2004 | Text | 30 | City name of member  Refer to Appendix A |
|  |  |  |  |  |  |
| **ME016** | **Member State or Province** | 4/1/2004 | Text | 2 | As defined by the US Postal Service and Canada Post  Refer to Appendix A |
|  |  |  |  |  |  |
| **ME017** | **Member ZIP Code** | 1/1/2003 | Text | 11 | ZIP Code of member – may include non-US codes. Do not include dash  Refer to Appendix A |
|  |  |  |  |  |  |
| **ME018** | **Medical Coverage** | 1/1/2003 | Text | 1 | N No  Y Yes |
|  |  |  |  |  |  |
| ME019 | Prescription Drug Coverage | 1/1/2003 | Text | 1 | N No  Y Yes |
|  |  |  |  |  |  |
| **ME020** | **Dental Coverage** | 1/1/2003 | Text | 1 | N No  Y Yes |
|  |  |  |  |  |  |
| **ME021** | **Race 1** | 1/1/2021 | Text | 2 | Report the Member-identified 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. Refer to Appendix A.  For quick reference, the two-character subset of the CDC race list is:  R1 American Indian/Alaska Native  R2 Asian  R3 Black/African American  R4 Native Hawaiian or Other Pacific Islander |
|  |  |  |  |  | R5 White  R9 Other Race  UN Unknown/Not Specified |
|  |  |  |  |  |  |
| **ME022** | **Race 2** | 1/1/2021 | Text | 2 | Report the Member-identified 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. Refer to Appendix A. |
|  |  |  |  |  |  |
| **ME023** | **Race 3** | 1/1/2021 | Text | 2 | Report the Member-identified 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. Refer to Appendix A. |
|  |  |  |  |  |  |
| **ME024** | **Hispanic Indicator** | 1/1/2021 | Text | 1 | Report the value that defines the element. The code value “U” for unknown, should be used ONLY when member 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. |
|  |  |  |  |  |  |
| **ME025** | **Ethnicity 1** | 1/1/2021 | Text | 6 | Report the Member-identified ethnicity from the External Code Source that best describes the information obtained from the Member / Subscriber. The value “UNKNOW” should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data. If not available, leave blank. Refer to Appendix A. |
|  |  |  |  |  |  |
| **ME026** | **Ethnicity 2** | 1/1/2021 | Text | 6 | Report the Member-identified ethnicity from the External Code Source that best describes the information obtained from the Member / Subscriber. The value “UNKNOW” should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data. If not available, leave blank. Refer to Appendix A. |
|  |  |  |  |  |  |
| **ME027** | **Ethnicity 3** | 1/1/2021 | Text | 6 | Report the Member-identified ethnicity from the External Code Source that best describes the information obtained from the Member / Subscriber. The |
|  |  |  |  |  |  |
|  |  |  |  |  | value “UNKNOW” should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data. If not available, leave blank. Refer to Appendix A. |
|  |  |  |  |  |  |
| **ME028** | **Primary Insurance Indicator** | 1/1/2010 | Number | 1 | 1 Yes – primary insurance  2 No – secondary, or tertiary insurance |
|  |  |  |  |  |  |
| **ME029** | **Coverage Type** | 1/1/2010 | Text | 3 | ASO – self-funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess, insurance coverage |
|  |  |  |  |  | ASW – self-funded plans that are administered by a third-party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage |
|  |  |  |  |  | OTH – any other plan. Insurers using this code shall obtain prior approval. |
|  |  |  |  |  | STN – short-term, non-renewable health insurance |
|  |  |  |  |  | UND – plans underwritten by the insurer |
|  |  |  |  |  |  |
| **ME030** | **Market Category Code** | 1/1/2010 | Text | 4 | IND – coverage sold and issued directly to individuals (non-group) |
|  |  |  |  |  | FCH – coverage sold and issued directly to individuals on a franchise basis |
|  |  |  |  |  | GCV – coverage sold and issued directly to individuals as group conversion policies |
|  |  |  |  |  | GS1 – coverage sold and issued directly to employers having exactly one employee |
|  |  |  |  |  | GS2 – coverage sold and issued directly to employers having between two and nine employees |
|  |  |  |  |  | GS3 – coverage sold and issued directly to employers having between 10 and 25 employees |
|  |  |  |  |  | GS4 – coverage sold and issued directly to employers having between 26 and 50 employees |
|  |  |  |  |  | GLG1 – coverage sold and issued directly to employers having between 51 and 99 employees |
|  |  |  |  |  | GLG2 – coverage sold and issued directly to employers having 100 or more employees |
|  |  |  |  |  | GSA – coverage sold and issued directly to small employers through a qualified association trust |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  | OTH – coverage sold to other types of entities. Insurers using this market code shall obtain prior approval. |
|  |  |  |  |  |  |
| **ME031** | **Special Coverage** | N/A | Number | 3 | State-specific assignment. Default value for Maine is “0”. |
|  |  |  |  |  |  |
| **ME032** | **Group Name** | 1/1/2010 | Text | 128 | Group name or IND for individual policies, and BLANK if data  is not available |
|  |  |  |  |  |  |
| **ME101** | **Subscriber Last Name** | 1/1/2010 | Text | 60 | The subscriber last name |
|  |  |  |  |  |  |
| **ME102** | **Subscriber First Name** | 1/1/2010 | Text | 35 | The subscriber first name |
|  |  |  |  |  |  |
| **ME103** | **Subscriber Middle Name** | 1/1/2010 | Text | 25 | The subscriber middle name or initial |
|  |  |  |  |  |  |
| **ME104** | **Member Last Name** | 1/1/2010 | Text | 60 | The member last name |
|  |  |  |  |  |  |
| **ME105** | **Member First Name** | 1/1/2010 | Text | 35 | The member first name |
|  |  |  |  |  |  |
| **ME106** | **Member Middle Name** | 1/1/2010 | Text | 25 | The member middle name or initial |
|  |  |  |  |  |  |
| **ME107** | **Member Address Line 1** | 2/1/2019 | Text | 55 |  |
|  |  |  |  |  |  |
| **ME108** | **Member Address Line 2** | 2/1/2019 | Text | 55 |  |
|  |  |  |  |  |  |
| **ME109** | **Member Country Code** | 2/1/2019 | Text | 2 | Use ISO 3166-1 alpha-2 country codes. Refer to Appendix A. |
|  |  |  |  |  |  |
| **ME110** | **Subscriber HICN** | 2/1/2019 | Text | 11 | Subscriber’s Health Insurance Claim Number. Populate at least once starting February 1, 2019 and at least until MBI is reported. |
|  |  |  |  |  |  |
| **ME111** | **Subscriber MBI** | 2/1/2019 | Text | 11 | Subscriber’s Medicare Beneficiary Identifier. May be populated starting February 1, 2019 or as soon as MBI is available for reporting. Required starting January 1, 2020 or if ME110 is not present. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **ME112** | **Member HICN** | 2/1/2019 | Text | 11 | Member’s Health Insurance Claim Number. Required only for Medicare Supplemental/Companion Plans for which 1) the subscriber and the member are not the same person and 2) the payer is primary. Otherwise, leave blank. If not the same as ME110, populate at least once starting February 1, 2019 and at least until Member MBI is reported. |
|  |  |  |  |  |  |
| **ME113** | **Member MBI** | 2/1/2019 | Text | 11 | Member’s Medicare Beneficiary Identifier. Required only for Medicare Supplemental/Companion Plans for which 1) the subscriber and the member are not the same person, 2) the payer is primary and 3) ME112 is not present. Otherwise, leave blank. If not the same as ME111, may be populated starting February 1, 2019; however, only required starting January 1, 2020. |
|  |  |  |  |  |  |
| **ME114** | **Plan Begin Date**  **(Member Effective Date)** | 2/1/2020 | Text | 8 | CCYYMMDD. Effective date of coverage. Date eligibility started for this member under this plan type. |
|  |  |  |  |  |  |
| **ME115** | **Plan End Date**  **(Member Cancellation Date)** | 2/1/2020 | Text | 8 | CCYYMMDD. Last continuous day of coverage (date eligibility ended) for this member under this plan. For open contracts, leave blank. |
|  |  |  |  |  |  |
| **ME899** | **Record Type** | 1/1/2003 | Text | 2 | ME |

|  |  | HIPAA Reference ASC X12N/005010 |
| --- | --- | --- |
| Data |  | **Transaction Set/Loop/** |
| Element |  | **Segment ID/Code Value/** |
| **#** | **Data Element Name** | **Reference Designator** |
| ME001 | Submitter | N/A |
| ME002 | Payer | N/A |
| ME003 | Insurance Type/Product Code | 271/2110C/EB/04, 271/2110D/EB/04 |
| ME004 | Year | N/A |
| ME005 | Month | N/A |
| ME006 | Insured Group or Policy Number | 271/2100C/REF/1L/02, 271/2100C/REF/IG/02, |
|  |  | 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02, |
| ME007 | Coverage Level Code | 271/2110C/EB/02, 271/2110D/EB/02 |
| ME008 | Subscriber Social Security Number | 271/2100C/REF/SY/02 |
| ME009 | Plan Specific Contract Number | 271/2100C/NM1/MI/09 |
| ME010 | Member Suffix or Sequence Number | 271/2100C/REF/49/02, 271/2100D/REF/49/02 |
| ME011 | Member Identification Code | 271/2100C/REF/SY/02, 271/2100D/REF/SY/02 |
| ME012 | Individual Relationship Code | 271/2100C/INS/Y/02, 271/2100D/INS/N/02 |
| ME013 | Member Gender | 271/2100C/DMG/03, 271/2100D/DMG/03 |
| ME014 | Member Date of Birth | 271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02 |
| ME015 | Member City Name | 271/2100C/N4/01, 271/2100D/N4/01 |
| ME016 | Member State or Province | 271/2100C/N4/02, 271/2100D/N4/02 |
| ME017 | Member ZIP Code | 271/2100C/N4/03, 271/2100D/N4/03 |
| ME018 | Medical Coverage | N/A |
| ME019 | Prescription Drug Coverage | N/A |
| ME020 | Dental Coverage | N/A |
| ME021 | Race 1 | N/A |
| ME022 | Race 2 | N/A |
| ME023 | Race 3 | N/A |
| ME024 | Hispanic Indicator | N/A |
| ME025 | Ethnicity 1 | N/A |
| ME026 | Ethnicity 2 | N/A |
| ME027 | Ethnicity 3 | N/A |
| ME028 | Primary Insurance Indicator | N/A |
| ME029 | Coverage Type | N/A |
| ME030 | Market Category Code | N/A |
| ME031 | Special Coverage | N/A |
| ME032 | Group Name | 271/2100C/REF/18/03, 271/2100D/REF/28/03, 271/2100C/REF/6P/03, 271/2100D/REF/6P/03, 271/2100C/REF/N6/03, 271/2100D/REF/N6/03 |
| ME101 | Subscriber Last Name | 271/2100C/NM1/ /03 |
| ME102 | Subscriber First Name | 271/2100C/NM1/ /04 |
| ME103 | Subscriber Middle Name | 271/2100C/NM1/ /05 |
| ME104 | Member Last Name | 271/2100C/NM1/ /03, 271/2100D/NM1/ /03 |
| ME105 | Member First Name | 271/2100C/NM1/ /04, 271/2100D/NM1/ /04 |
| ME106 | Member Middle Name | 271/2100C/NM1/ /05, 271/2100D/NM1/ /05 |
| ME107 | Member Address Line 1 | 271/2100C/N3/01, 271/2100D/N3/01 |
| ME108 | Member Address Line 2 | 271/2100C/N3/02, 271/2100D/N3/02 |
| ME109 | Member Country Code | 271/2100C/N4/04, 271/2100D/N4/04 |
| ME110 | Subscriber HICN | 271/2100C/NM1/MI/09 |
| ME111 | Subscriber MBI | 271/2100C/NM1/MI/09 |
| ME112 | Member HICN | 271/2100D/NM1/MI/09, 271/2100D/REF/F6/02 |
| ME113 | Member MBI | 271/2100D/NM1/MI/09, 271/2100D/REF/F6/02 |
| ME114 | Plan Begin Date  (Member Effective Date) | 271/2100C/DTP/346/D8, 271/2100D/DTP/346/D8 |
| ME115 | Plan End Date  (Member Cancellation Date) | 271/2100C/DTP/347/D8, 271/2100D/DTP/347/D8 |
| ME899 | Record Type | N/A |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Data Element #** | **Data Element Name** | Date Effective | **Type** | **Maximum**  **Length** | **Description/Codes/Sources** |
|  |  |  |  |  |  |
| **MC001** | **Submitter** | 1/1/2003 | Text | 8 | MHDO-assigned identifier of payer submitting claims data. Do not  leave blank. |
|  |  |  |  |  |  |
| **MC002** | **Payer** | 7/1/2012 | Text | 8 | MHDO-assigned code of the insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Do not leave blank. |
|  |  |  |  |  |  |
| **MC003** | Insurance Type/Product Code | 1/1/2003 | Text | 2 | Code identifying the type of insurance policy within a specific insurance program. Refer to Appendix A |
|  |  |  |  |  | 16 Medicare Part C |
|  |  |  |  |  | MD Medicare Part D |
|  |  |  |  |  | SP Supplemental Policy |
|  |  |  |  |  |  |
| **MC004** | **Payer Claim Control Number** | 1/1/2003 | Text | 35 | Must apply to the entire claim and be unique within the payer’s system |
|  |  |  |  |  |  |
| **MC005** | **Line Counter** | 4/1/2004 | Number | 4 | Line number for this service |
|  |  |  |  |  | The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. |
|  |  |  |  |  |  |
| **MC005A** | **Version Number** | 1/1/2010 | Number | 4 | The version number of this claim service line. |
|  |  |  |  |  | The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line. |
|  |  |  |  |  |  |
| **MC006** | **Insured Group or Policy Number** | 1/1/2003 | Text | 30 | Group or policy number – not the number that uniquely identifies the subscriber. |
|  |  |  |  |  |  |
| **MC007** | **Subscriber Social Security Number** | 1/1/2003 | Text | 9 | Subscriber’s social security number  Leave blank if unavailable. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC008** | **Plan Specific Contract Number** | 1/1/2003 | Text | 80 | Plan assigned contract number  Leave blank if contract number = subscriber’s social security number. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC009** | **Member Suffix or Sequence Number** | 1/1/2003 | Text | 20 | Uniquely numbers the member within the contract. |
|  |  |  |  |  |  |
| **MC010** | **Member Identification Code** | 1/1/2003 | Text | 50 | Member’s social security number  Leave blank if unavailable. |
|  |  |  |  |  |  |
| **MC011** | **Individual Relationship Code** | 1/1/2003 | Text | 2 | Member’s relationship to insured  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC012** | **Member Gender** | 1/1/2003 | Text | 1 | Refer to Appendix A |
|  |  |  |  |  |  |
| **MC013** | **Member Date of Birth** | 1/1/2003 | Text | 8 | CCYYMMDD |
|  |  |  |  |  |  |
| **MC014** | **Member City Name** | 4/1/2004 | Text | 30 | City name of member  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC015** | **Member State or Province** | 4/1/2004 | Text | 2 | As defined by the US Postal Service and Canada Post  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC016** | **Member ZIP Code** | 1/1/2003 | Text | 11 | ZIP Code of member – may include non-US codes  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC017** | **Date Service Approved (AP Date)** | 1/1/2003 | Text | 8 | CCYYMMDD |
|  |  |  |  |  |  |
| **MC018** | **Admission Date** | 1/1/2003 | Text | 8 | Required for all inpatient claims |
|  |  |  |  |  | CCYYMMDD |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC019** | Admission Hour | 4/1/2004 | Text | 2 | Required for all inpatient claims |
|  |  |  |  |  | Time is expressed in military time – HH |
|  |  |  |  |  |  |
| **MC020** | **Priority (Type) of Admission or Visit** | 4/1/2004 | Number | 1 | Required for all inpatient claims  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC021** | **Point of Origin for Admission or Visit** | 4/1/2004 | Text | 1 | Required for all inpatient claims  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC022** | **Discharge Hour** | 4/1/2004 | Text | 2 | Time expressed in military time – HH |
|  |  |  |  |  |  |
| **MC023** | **Patient Discharge Status** | 1/1/2003 | Text | 2 | Required for all inpatient claims  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC024** | **Rendering Provider Number** | 1/1/2003 | Text | 30 | Payer assigned rendering provider number |
|  |  |  |  |  |  |
| **MC025** | **Rendering Provider Tax ID Number** | 1/1/2003 | Text | 10 | Federal taxpayer’s identification number |
|  |  |  |  |  |  |
| **MC026** | **National Provider ID – Rendering Provider** | 4/1/2004 | Text | 20 | National Provider ID for Rendering Provider  This data element pertains to the entity or individual directly providing the service.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC027** | **Rendering Provider Entity Type Qualifier** | 4/1/2004 | Number | 1 | HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a “person”, and these shall be coded as a person.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC028** | **Rendering Provider First Name** | 1/1/2003 | Text | 40 | Individual first name  Leave blank if provider is a facility or organization. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC029** | **Rendering Provider Middle Name** | 1/1/2003 | Text | 25 | Individual middle name or initial  Leave blank if provider is a facility or organization. |
|  |  |  |  |  |  |
| **MC030** | **Rendering Provider Last Name or Organization Name** | 1/1/2003 | Text | 60 | Full name of provider organization or last name of individual provider |
|  |  |  |  |  |  |
| **MC031** | **Rendering Provider Suffix** | 1/1/2003 | Text | 10 | Suffix to individual name  Leave blank if provider is a facility or organization. |
|  |  |  |  |  | The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III), if applicable, rather than the clinician’s degree (e.g., MD, LCSW). |
|  |  |  |  |  |  |
| **MC032** | **Rendering Provider Specialty** | 1/1/2003 | Text | 10 | Refer to Appendix A  If defined by payer, then dictionary for specialty code values must be supplied during testing. |
|  |  |  |  |  |  |
| **MC033** | **Placeholder** | 10/1/2014 | N/A | 0 | Leave blank  Service Provider City Name retired; refer to MC089 – Service Facility Location City Name |
|  |  |  |  |  |  |
| **MC034** | **Placeholder** | 10/1/2014 | N/A | 0 | Leave blank  Service Provider State or Province retired; refer to MC090 – Service Facility Location Address State or Province |
|  |  |  |  |  |  |
| **MC035** | **Placeholder** | 10/1/2014 | N/A | 0 | Leave blank  Service Provider ZIP Code retired; refer to MC091 – Service Facility Location Address State or Province |
|  |  |  |  |  |  |
| **MC036** | **Type of Bill – Institutional** | 4/1/2004 | Text | 3 | Required for institutional claims  Not to be used for professional claims  Exclude leading zero, but include frequency indicator, if present  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC037** | **Place of Service – Professional** | 4/1/2004 | Text | 2 | Required for professional claims  Not to be used for institutional claims  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC038** | **Claim Status** | 1/1/2003 | Text | 2 | Refer to Appendix A |
|  |  |  |  |  |  |
| **MC039** | **Admitting Diagnosis** | 4/1/2004 | Text | 5 | Required on all inpatient admission claims and encounters |
|  |  |  |  |  | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC040** | **E-Code** | 4/1/2004 | Text | 5 | Describes an injury, poisoning or adverse effect |
|  |  |  |  |  | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC041** | **Principal Diagnosis** | 1/1/2003 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC042** | **Other Diagnosis – 1** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC043** | **Other Diagnosis – 2** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC044** | **Other Diagnosis – 3** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC045** | **Other Diagnosis – 4** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC046** | **Other Diagnosis – 5** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC047** | **Other Diagnosis – 6** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC048** | **Other Diagnosis – 7** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC049** | **Other Diagnosis – 8** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC050** | **Other Diagnosis – 9** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC051** | **Other Diagnosis – 10** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC052** | **Other Diagnosis – 11** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC053** | **Other Diagnosis – 12** | 4/1/2004 | Text | 5 | ICD-9-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC054** | **Revenue Code** | 1/1/2003 | Text | 4 | National Uniform Billing Committee Codes  Code using leading zeroes, left justified, and four digits.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC055** | **Procedure Code** | 1/1/2003 | Text | 10 | Health Care Common Procedural Coding System (HCPCS), the CPT codes of the American Medical Association, the CDT from the American Dental Association, and the HIPPS codes from the Health Insurance Prospective Payment System. |
|  |  |  |  |  | Refer to Appendix A |
|  |  |  |  |  |  |
| **MC056** | **Procedure Modifier – 1** | 1/1/2003 | Text | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC057** | **Procedure Modifier – 2** | 1/1/2003 | Text | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. |
|  |  |  |  |  |  |
| **MC057A** | **Procedure Modifier – 3** | 10/1/2014 | Text | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. |
|  |  |  |  |  |  |
| **MC057B** | **Procedure Modifier – 4** | 10/1/2014 | Text | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. |
|  |  |  |  |  |  |
| **MC058** | **ICD-9-CM Procedure Code** | 1/1/2003 | Text | 4 | Primary procedure code for this line of service  Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC059** | **Date of Service – From** | 1/1/2003 | Text | 8 | First date of service for this service line  CCYYMMDD |
|  |  |  |  |  |  |
| **MC060** | **Date of Service – Thru** | 1/1/2003 | Text | 8 | Last date of service for this service line  CCYYMMDD |
|  |  |  |  |  |  |
| **MC061** | **Quantity** | 1/1/2003 | Number | 10 | Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay. Code decimal point. |
|  |  |  |  |  |  |
| **MC062** | **Charge Amount** | 1/1/2003 | Number | 10 | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **MC063** | **Paid Amount** | 1/1/2003 | Number | 10 | Includes any withhold amounts |
|  |  |  |  |  | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **MC064** | **Prepaid Amount** | 1/1/2003 | Number | 10 | For capitated services, the fee for service equivalent amount |
|  |  |  |  |  | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **MC065** | **Co-pay Amount** | 1/1/2003 | Number | 10 | The preset, fixed dollar amount for which the individual is responsible. |
|  |  |  |  |  | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **MC066** | **Coinsurance Amount** | 1/1/2003 | Number | 10 | The dollar amount an individual is responsible for – not the percentage.  Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **MC067** | **Deductible Amount** | 1/1/2003 | Number | 10 | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **MC068** | **Patient Account/Control Number** | 7/1/2006 | Text | 20 | Identifier assigned by hospital |
|  |  |  |  |  |  |
| **MC069** | **Discharge Date** | 7/1/2006 | Text | 8 | Date patient discharged  Required for all inpatient claims.  CCYYMMDD |
|  |  |  |  |  |  |
| **MC070** | **Placeholder** | 2/1/2016 | N/A | 0 | Leave blank  Service Provider Country Name retired. |
|  |  |  |  |  |  |
| **MC071** | **DRG** | 1/1/2010 | Text | 10 | Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an “A” prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX).  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC072** | **DRG Version** | 1/1/2010 | Text | 2 | Version number of the grouper used |
|  |  |  |  |  |  |
| **MC073** | **APC** | 1/1/2010 | Text | 5 | Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC074** | **APC Version** | 1/1/2010 | Text | 2 | Version number of the grouper used |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC075** | **Drug Code** | 1/1/2010 | Text | 11 | An NDC code used only when a medication is paid for as part of a medical claim.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC076** | **Billing Provider Number** | 1/1/2010 | Text | 30 | Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and  does not routinely change. |
|  |  |  |  |  |  |
| **MC077** | **National Provider ID – Billing Provider** | 1/1/2010 | Text | 20 | National Provider ID for billing provider  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC078** | **Billing Provider Last Name or Organization Name** | 1/1/2010 | Text | 60 | Full name of provider billing organization or last name of individual billing provider. |
|  |  |  |  |  |  |
| **MC079** | **Billing Provider Tax ID** | 10/1/2014 | Text | 10 | Federal taxpayer's identification number |
|  |  |  |  |  |  |
| **MC080** | **Billing Provider Address Line 1** | 10/1/2014 | Text | 55 | Address information for billing provider |
|  |  |  |  |  |  |
| **MC081** | **Billing Provider Address Line 2** | 10/1/2014 | Text | 55 | Address information for billing provider |
|  |  |  |  |  |  |
| **MC082** | **Billing Provider City Name** | 10/1/2014 | Text | 30 | City name of billing provider  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC083** | **Billing Provider State or Province** | 10/1/2014 | Text | 2 | As defined by the US Postal Service and Canada Post  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC084** | **Billing Provider Zip Code** | 10/1/2014 | Text | 11 | ZIP Code of billing provider - may include non-US codes  Do not include dash  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC085** | **Service Facility Location Name** | 10/1/2014 | Text | 60 | Laboratory or service facility name  If blank or not specified, populate with MC078 -- Billing Provider Last Name or Organization Name. |
|  |  |  |  |  |  |
| **MC086** | **National Provider ID – Service Facility** | 10/1/2014 | Text | 20 | National Provider ID for laboratory or service facility  If blank or not specified, populate with MC077 -- National Provider ID –  Billing Provider.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC087** | **Service Facility Location Address Line 1** | 10/1/2014 | Text | 55 | Address information for laboratory or service facility  If blank or not specified, populate with MC080 -- Billing Provider  Address Line 1. |
|  |  |  |  |  |  |
| **MC088** | **Service Facility Location Address Line 2** | 10/1/2014 | Text | 55 | Address information for laboratory or service facility  If blank or not specified, populate with MC081 -- Billing Provider  Address Line 2. |
|  |  |  |  |  |  |
| **MC089** | **Service Facility Location City Name** | 10/1/2014 | Text | 30 | City name of laboratory or service facility  If blank or not specified, populate with MC082 -- Billing Provider  City Name.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC090** | **Service Facility Location State or Province** | 10/1/2014 | Text | 2 | As defined by the US Postal Service and Canada Post  If blank or not specified, populate with MC083 -- Billing Provider  State or Province.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC091** | **Service Facility Location Zip Code** | 10/1/2014 | Text | 11 | ZIP Code of service facility - may include non-US codes  Do not include dash  If blank or not specified, populate with MC084 -- Billing Provider  Zip Code.  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC092** | **Service Facility Number** | 2/1/2016 | Text | 30 | Payer assigned service facility number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change.  If blank or not specified, populate with MC076 -- Billing Provider  Number. |
|  |  |  |  |  |  |
| **MC093** | **Service Facility Location Country Code** | 2/1/2016 | Text | 2 | Use ISO 3166-1 alpha-2 country codes. Refer to Appendix A. |
|  |  |  |  |  |  |
| **MC094** | **Billing Provider Country Code** | 2/1/2016 | Text | 2 | Use ISO 3166-1 alpha-2 country codes. Refer to Appendix A. |
|  |  |  |  |  |  |
| **MC101** | **Subscriber Last Name** | 1/1/2010 | Text | 60 | The subscriber last name |
|  |  |  |  |  |  |
| **MC102** | **Subscriber First Name** | 1/1/2010 | Text | 35 | The subscriber first name |
|  |  |  |  |  |  |
| **MC103** | **Subscriber Middle Name** | 1/1/2010 | Text | 25 | The subscriber middle name or initial |
|  |  |  |  |  |  |
| **MC104** | **Member Last Name** | 1/1/2010 | Text | 60 | The member last name |
|  |  |  |  |  |  |
| **MC105** | **Member First Name** | 1/1/2010 | Text | 35 | The member first name |
|  |  |  |  |  |  |
| **MC106** | **Member Middle Name** | 1/1/2010 | Text | 25 | The member middle name or initial |
|  |  |  |  |  |  |
| **MC107** | **Attending Provider Number** | 2/1/2016 | Text | 30 | Payer assigned attending provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. |
|  |  |  |  |  |  |
| **MC108** | **National Provider ID – Attending Provider** | 2/1/2016 | Text | 20 | National Provider ID for attending provider  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC109** | **Attending Provider First Name** | 2/1/2016 | Text | 40 | Individual first name |
|  |  |  |  |  |  |
| **MC110** | **Attending Provider Middle Name** | 2/1/2016 | Text | 25 | Individual middle name or initial |
|  |  |  |  |  |  |
| **MC111** | **Attending Provider Last Name** | 2/1/2016 | Text | 60 | Individual last name |
|  |  |  |  |  |  |
| **MC112** | **Attending Provider Suffix** | 2/1/2016 | Text | 10 | Individual name suffix  The attending provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III), if applicable, rather than the clinician’s degree (e.g., MD, LCSW). |
|  |  |  |  |  |  |
| **MC113** | **Attending Provider Specialty** | 2/1/2016 | Text | 10 | Refer to Appendix A  If defined by payer, then dictionary for specialty code values must be supplied during testing. |
|  |  |  |  |  |  |
| **MC114** | **Operating Provider Number** | 2/1/2016 | Text | 30 | Payer assigned operating provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. |
|  |  |  |  |  |  |
| **MC115** | **National Provider ID – Operating Provider** | 2/1/2016 | Text | 20 | National Provider ID for operating provider  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC116** | **Operating Provider First Name** | 2/1/2016 | Text | 40 | Individual first name |
|  |  |  |  |  |  |
| **MC117** | **Operating Provider Middle Name** | 2/1/2016 | Text | 25 | Individual middle name or initial |
|  |  |  |  |  |  |
| **MC118** | **Operating Provider Last Name** | 2/1/2016 | Text | 60 | Individual last name |
|  |  |  |  |  |  |
| **MC119** | **Operating Provider Suffix** | 2/1/2016 | Text | 10 | Individual name suffix  The operating provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III), if applicable, rather than the clinician’s degree (e.g., MD, LCSW). |
|  |  |  |  |  |  |
| **MC120** | **Referring Provider Number** | 2/1/2016 | Text | 30 | Payer assigned referring provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. |
|  |  |  |  |  |  |
| **MC121** | **National Provider ID – Referring Provider** | 2/1/2016 | Text | 20 | National Provider ID for referring provider  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC122** | **Referring Provider First Name** | 2/1/2016 | Text | 40 | Individual first name |
|  |  |  |  |  |  |
| **MC123** | **Referring Provider Middle Name** | 2/1/2016 | Text | 25 | Individual middle name or initial |
|  |  |  |  |  |  |
| **MC124** | **Referring Provider Last Name** | 2/1/2016 | Text | 60 | Individual last name |
|  |  |  |  |  |  |
| **MC125** | **Referring Provider Suffix** | 2/1/2016 | Text | 10 | Individual name suffix  The referring provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III), if applicable, rather than the clinician’s degree (e.g., MD, LCSW). |
|  |  |  |  |  |  |
| **MC200** | **Principal Diagnosis** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC201** | **Present On Admission Indicator** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC202** | **Admitting Diagnosis** | 10/1/2004 | Text | 7 | Required on all inpatient admission claims and encounters |
|  |  |  |  |  | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
| **MC203** | **Reason for Visit Diagnosis - 1** | 10/1/2014 | Text | 7 | ICD-10 CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC204** | **Reason for Visit Diagnosis - 2** | 10/1/2014 | Text | 7 | ICD-10 CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC205** | **Reason for Visit Diagnosis - 3** | 10/1/2014 | Text | 7 | ICD-10 CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC206** | **External Cause of Injury - 1** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC207** | **Present On Admission Indicator - 1** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC208** | **External Cause of Injury - 2** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC209** | **Present On Admission Indicator - 2** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC210** | **External Cause of Injury - 3** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC211** | **Present On Admission Indicator - 3** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC212** | **External Cause of Injury - 4** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC213** | **Present On Admission Indicator - 4** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC214** | **External Cause of Injury - 5** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC215** | **Present On Admission Indicator - 5** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC216** | **External Cause of Injury - 6** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC217** | **Present On Admission Indicator - 6** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC218** | **External Cause of Injury - 7** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC219** | **Present On Admission Indicator - 7** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC220** | **External Cause of Injury - 8** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC221** | **Present On Admission Indicator - 8** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC222** | **External Cause of Injury - 9** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC223** | **Present On Admission Indicator - 9** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC224** | **External Cause of Injury - 10** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC225** | **Present On Admission Indicator - 10** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC226** | **External Cause of Injury - 11** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC227** | **Present On Admission Indicator - 11** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC228** | **External Cause of Injury - 12** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC229** | **Present On Admission Indicator - 12** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC230** | **External Cause of Injury - 13** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC231** | **Present On Admission Indicator - 13** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC232** | **External Cause of Injury - 14** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC233** | **Present On Admission Indicator - 14** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC234** | **External Cause of Injury - 15** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC235** | **Present On Admission Indicator - 15** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC236** | **External Cause of Injury - 16** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC237** | **Present On Admission Indicator - 16** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC238** | **External Cause of Injury - 17** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC239** | **Present On Admission Indicator - 17** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC240** | **External Cause of Injury - 18** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC241** | **Present On Admission Indicator - 18** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC242** | **External Cause of Injury - 19** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC243** | **Present On Admission Indicator - 19** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC244** | **External Cause of Injury - 20** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC245** | **Present On Admission Indicator - 20** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC246** | **External Cause of Injury - 21** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC247** | **Present On Admission Indicator - 21** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC248** | **External Cause of Injury - 22** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC249** | **Present On Admission Indicator - 22** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC250** | **External Cause of Injury - 23** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC251** | **Present On Admission Indicator - 23** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC252** | **External Cause of Injury - 24** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC253** | **Present On Admission Indicator - 24** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC254** | **Other Diagnosis – 1** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC255** | **Present On Admission Indicator – 1** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC256** | **Other Diagnosis – 2** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC257** | **Present On Admission Indicator – 2** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC258** | **Other Diagnosis – 3** | 10/1/2004 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC259** | **Present On Admission Indicator – 3** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC260** | **Other Diagnosis – 4** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC261** | **Present On Admission Indicator – 4** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC262** | **Other Diagnosis – 5** | 10/1/2004 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC263** | **Present On Admission Indicator – 5** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC264** | **Other Diagnosis – 6** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC265** | **Present On Admission Indicator – 6** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC266** | **Other Diagnosis – 7** | 10/1/2004 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC267** | **Present On Admission Indicator – 7** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC268** | **Other Diagnosis – 8** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC269** | **Present On Admission Indicator – 8** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC270** | **Other Diagnosis – 9** | 10/1/2004 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC271** | **Present On Admission Indicator – 9** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC272** | **Other Diagnosis – 10** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC273** | **Present On Admission Indicator – 10** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC274** | **Other Diagnosis – 11** | 10/1/2004 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC275** | **Present On Admission Indicator – 11** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC276** | **Other Diagnosis – 12** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC277** | **Present On Admission Indicator – 12** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC278** | **Other Diagnosis – 13** | 10/1/2004 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC279** | **Present On Admission Indicator – 13** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC280** | **Other Diagnosis – 14** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC281** | **Present On Admission Indicator – 14** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC282** | **Other Diagnosis – 15** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC283** | **Present On Admission Indicator – 15** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC284** | **Other Diagnosis – 16** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC285** | **Present On Admission Indicator – 16** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC286** | **Other Diagnosis – 17** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC287** | **Present On Admission Indicator – 17** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC288** | **Other Diagnosis – 18** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC289** | **Present On Admission Indicator – 18** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC290** | **Other Diagnosis – 19** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC291** | **Present On Admission Indicator – 19** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC292** | **Other Diagnosis – 20** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC293** | **Present On Admission Indicator – 20** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC294** | **Other Diagnosis – 21** | 10/1/2004 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC295** | **Present On Admission Indicator – 21** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC296** | **Other Diagnosis – 22** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC297** | **Present On Admission Indicator – 22** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC298** | **Other Diagnosis – 23** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC299** | **Present On Admission Indicator – 23** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC300** | **Other Diagnosis – 24** | 10/1/2014 | Text | 7 | ICD-10-CM Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC301** | **Present On Admission Indicator – 24** | 10/1/2014 | Text | 1 | Standard POA code set  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC302** | **Principal Procedure Code** | 10/1/2014 | Text | 7 | IDC-10-PCS Primary procedure code for this line of service  Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC303** | **Other Procedure Code - 1** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC304** | **Other Procedure Code - 2** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC305** | **Other Procedure Code - 3** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC306** | **Other Procedure Code - 4** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC307** | **Other Procedure Code - 5** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC308** | **Other Procedure Code - 6** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC309** | **Other Procedure Code - 7** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC310** | **Other Procedure Code - 8** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC311** | **Other Procedure Code - 9** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC312** | **Other Procedure Code - 10** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC313** | **Other Procedure Code - 11** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC314** | **Other Procedure Code - 12** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
| **MC315** | **Other Procedure Code - 13** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC316** | **Other Procedure Code - 14** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC317** | **Other Procedure Code - 15** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC318** | **Other Procedure Code - 16** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC319** | **Other Procedure Code - 17** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC320** | **Other Procedure Code - 18** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC321** | **Other Procedure Code - 19** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC322** | **Other Procedure Code - 20** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC323** | **Other Procedure Code - 21** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC324** | **Other Procedure Code - 22** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **MC325** | **Other Procedure Code - 23** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC326** | **Other Procedure Code - 24** | 10/1/2014 | Text | 7 | ICD-10 PCS Do not code decimal point.  Refer to Appendix A |
|  |  |  |  |  |  |
| **MC327** | **Member Address Line 1** | 2/1/2019 | Text | 55 |  |
|  |  |  |  |  |  |
| **MC328** | **Member Address Line 2** | 2/1/2019 | Text | 55 |  |
|  |  |  |  |  |  |
| **MC329** | **Member Country Code** | 2/1/2019 | Text | 2 | Use ISO 3166-1 alpha-2 country codes. Refer to Appendix A. |
|  |  |  |  |  |  |
| **MC330** | **In-Plan Network Indicator** | 2/1/2021 | Text | 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. |
|  |  |  |  |  |  |
| **MC899** | **Record Type** | 1/1/2003 | Text | 2 | Value = MC |

|  |  |  |  | HIPAA Reference ASC X12N/005010A1 |
| --- | --- | --- | --- | --- |
| Data |  | **UB-04** | **CMS** | **Transaction Set/Loop/** |
| **Element** |  | **Form** | **1500** | **Segment ID/Code Value/** |
| **#** | **Data Element Name** | **Locator** | **#** | **Reference Designator** |
| MC001 | Submitter | N/A | N/A | N/A |
| MC002 | Payer | N/A | N/A | N/A |
| MC003 | Insurance Type/Product Code | N/A | N/A | 835/2100/CLP/06 |
| MC004 | Payer Claim Control Number | N/A | N/A | 835/2100/CLP/07 |
| MC005 | Line Counter | N/A | N/A | 837/2400/LX/01 |
| MC005A | Version Number | N/A | N/A | N/A |
| MC006 | Insured Group or Policy Number | 62 (A-C) | 11 | 837/2000B/SBR/03 |
| MC007 | Subscriber Social Security Number | N/A | N/A | 835/2100/NM1/MI/09 |
| MC008 | Plan Specific Contract Number | 60 (A-C) | 1a | 835/2100/NM1/MI/09 |
| MC009 | Member Suffix or Sequence Number | N/A | N/A | N/A |
| MC010 | Member Identification Code | N/A | N/A | 835/2100/NM1/34/09 |
| MC011 | Individual Relationship Code | 59 (A-C) | 6 | 837/2000B/SBR/02, 837/2000C/PAT/01 |
| MC012 | Member Gender | 11 | 3 | 837/2010BA/DMG/03, 837/2010CA/DMG/03 |
| MC013 | Member Date of Birth | 10 | 3 | 837/2010BA/DMG/D8/02, 837/2010CA/DMG/D8/02 |
| MC014 | Member City Name | 9b | 5 | 837/2010BA/N4/01, 837/2010CA/N4/01 |
| MC015 | Member State or Province | 9c | 5 | 837/2010BA/N4/02, 837/2010CA/N4/02 |
| MC016 | Member ZIP Code | 9d | 5 | 837/2010BA/N4/03, 837/2010CA/N4/03 |
| MC017 | Date Service Approved | N/A | N/A | 835/Header Financial Information/BPR/16 |
| MC018 | Admission Date | 12 | 18 | 837/2300/DTP/435/03 |
| MC019 | Admission Hour | 13 | N/A | 837/2300/DTP/435/03 |
| MC020 | Priority (Type) of Admission or Visit | 14 | N/A | 837/2300/CL1/01 |
| MC021 | Point of Origin for Admission or Visit | 15 | N/A | 837/2300/CL1/02 |
| MC022 | Discharge Hour | 16 | N/A | 837/2300/DTP/096/03 |
| MC023 | Patient Discharge Status | 17 | N/A | 837/2300/CL1/03 |
| MC024 | Rendering Provider Number | 57 | N/A | 835/2100/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09 |
| MC025 | Rendering Provider Tax ID Number | 5 | 25 (only if EIN) | 835/2100/NM1/FI/09 |
| MC026 | National Provider ID – Rendering Provider | 56 | 24J | professional:  837/2420A/NM1/XX/09; 837/2310B/NM1/XX/09;  institutional:  837/2010AA/NM1/XX/09 |
| MC027 | Rendering Provider Entity Type Qualifier | N/A | N/A | professional:  837/2420A/NM1/82/02; 837/2310B/NM1/82/02;  institutional:  837/2010AA/NM1/85/02 |
| MC028 | Rendering Provider First Name | N/A | 31 | professional:  837/2420A/NM1/82/04; 837/2310B/NM1/82/04;  institutional:  N/A |
| MC029 | Rendering Provider Middle Name | N/A | 31 | professional:  837/2420A/NM1/82/05; 837/2310B/NM1/82/05;  institutional:  N/A |
| MC030 | Rendering Provider Last Name or Organization Name | 1 | 31 | professional:  837/2420A/NM1/82/1/03; 837/2310B/NM1/82/1/03;  institutional:  837/2010AA/NM1/85/2/03 |
| MC031 | Rendering Provider Suffix | N/A | 31 | professional:  837/2420A/NM1/82/07; 837/2310B/NM1/82/07;  institutional:  N/A |
| MC032 | Rendering Provider Specialty | N/A | N/A | professional:  837/2420A/PRV/PXC/03;  837/2310B/PRV/PXC /03;  institutional:  837/2000A/PRV/PXC/03 |
| MC033 | Placeholder | N/A | N/A | N/A |
| MC034 | Placeholder | N/A | N/A | N/A |
| MC035 | Placeholder | N/A | N/A | N/A |
| MC036 | Type of Bill – Institutional | 4 | N/A | 837/2300/CLM/05-1 |
| MC037 | Place of Service - Professional | N/A | 24B | 837/2300/CLM/05-1 |
| MC038 | Claim Status | N/A | N/A | 835/2100/CLP/02 |
| MC039 | Admitting Diagnosis | 69 | N/A | 837/2300/HI/BJ/01-2 |
| MC040 | E-Code | 72 | N/A | 837/2300/HI/BN/01-2 |
| MC041 | Principal Diagnosis | 67 | 21.1 | 837/2300/HI/BK/01-2 |
| MC042 | Other Diagnosis – 1 | 67A | 21.2 | 837/2300/HI/BF/01-2 |
| MC043 | Other Diagnosis - 2 | 67B | 21.3 | 837/2300/HI/BF/02-2 |
| MC044 | Other Diagnosis - 3 | 67C | 21.4 | 837/2300/HI/BF/03-2 |
| MC045 | Other Diagnosis - 4 | 67D | N/A | 837/2300/HI/BF/04-2 |
| MC046 | Other Diagnosis - 5 | 67E | N/A | 837/2300/HI/BF/05-2 |
| MC047 | Other Diagnosis - 6 | 67F | N/A | 837/2300/HI/BF/06-2 |
| MC048 | Other Diagnosis - 7 | 67G | N/A | 837/2300/HI/BF/07-2 |
| MC049 | Other Diagnosis - 8 | 67H | N/A | 837/2300/HI/BF/08-2 |
| MC050 | Other Diagnosis - 9 | 67I | N/A | 837/2300/HI/BF/09-2 |
| MC051 | Other Diagnosis -10 | 67J | N/A | 837/2300/HI/BF/10-2 |
| MC052 | Other Diagnosis -11 | 67K | N/A | 837/2300/HI/BF/11-2 |
| MC053 | Other Diagnosis -12 | 67L | N/A | 837/2300/HI/BF/12-2 |
| MC054 | Revenue Code | 42 | N/A | 835/2110/SVC/NU/01-2, 835/2110/SVC/04 |
| MC055 | Procedure Code | 44 | 24D | 835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2 |
| MC056 | Procedure Modifier - 1 | 44 | 24D | 835/2110/SVC/HC/01-3 |
| MC057 | Procedure Modifier - 2 | 44 | 24D | 835/2110/SVC/HC/01-4 |
| MC057A | Procedure Modifier - 3 | 44 | 24D | 835/2110/SVC/HC/01-5 |
| MC057B | Procedure Modifier - 4 | 44 | 24D | 835/2110/SVC/HC/01-6 |
| MC058 | ICD-9-CM Procedure Code | 74 | N/A | 837/2300/HI/BR/01-2 |
| MC059 | Date of Service – From | 45 | 24A | 837/2400/DTP/472/D8 |
| MC060 | Date of Service – Thru | N/A | 24A | 837/2400/DTP/472/D8 |
| MC061 | Quantity | 46 | 24G | 835/2110/SVC/05 |
| MC062 | Charge Amount | 47 | 24F | 835/2110/SVC/02 |
| MC063 | Paid Amount | N/A | N/A | 835/2110/SVC/03 |
| MC064 | Prepaid Amount | N/A | N/A | 835/2110/CAS/CO/03 |
| MC065 | Co-pay Amount | N/A | N/A | 835/2110/CAS/PR/3-03 |
| MC066 | Coinsurance Amount | N/A | N/A | 835/2110/CAS/PR/2-03 |
| MC067 | Deductible Amount | N/A | N/A | 835/2110/CAS/PR/1-03 |
| MC068 | Patient Account/Control Number | 3a | 26 | 837/2300/CLM/01 |
| MC069 | Discharge Date | 6 | 18 | 837/2300/DTP/434/03 |
| MC070 | Placeholder | N/A | N/A | N/A |
| MC071 | DRG | N/A | N/A | 837/2300/HI/DR/01-2 |
| MC072 | DRG Version | N/A | N/A | N/A |
| MC073 | APC | N/A | N/A | 835/2110/REF/APC/02 |
| MC074 | APC Version | N/A | N/A | N/A |
| MC075 | Drug Code | N/A | N/A | 837/2410/LIN/N4/03 |
| MC076 | Billing Provider Number | 57 | 33b | 837/2010BB/REF/G2/02 |
| MC077 | National Provider ID – Billing Provider | 56 | 33a | 837/2010AA/NM1/85/ /XX/09 |
| MC078 | Billing Provider Last Name | 1 | 33 | 837/2010AA/NM1/85/ /03 |
| MC079 | Billing Provider Tax ID Number | NA | NA | 837/2010AA/REF/EI/02 |
| MC080 | Billing Provider Address Line 1 | 1 | 33 | 837/2010AA/N3/01 |
| MC081 | Billing Provider Address Line 2 | 1 | 33 | 837/2010AA/N3/02 |
| MC082 | Billing Provider City Name | 1 | 33 | 837/2010AA/N4/01 |
| MC083 | Billing Provider State or Province | 1 | 33 | 837/2010AA/N4/02 |
| MC084 | Billing Provider Zip Code | 1 | 33 | 837/2010AA/N4/03 |
| MC085 | Service Facility Location Name | 1 | 32 | professional:  837/2310C/NM1/77/2/03;  institutional:  837/2310E/NM1/77/2/03 |
| MC086 | National Provider ID – Service Facility | 56 | 32a | professional:  837/2310C/NM1/77/2/XX/09;  institutional:  837/2310E/NM1/77/2/XX/09 |
| MC087 | Service Facility Location Address Line 1 | 1 | 32 | professional:  837/2310C/N3/01;  institutional:  837/2310E/N3/01 |
| MC088 | Service Facility Location Address Line 2 | 1 | 32 | professional:  837/2310C/N3/02;  institutional:  837/2310E/N3/02 |
| MC089 | Service Facility Location City Name | 1 | 32 | professional:  837/2310C/N4/01;  institutional:  837/2310E/N4/01 |
| MC090 | Service Facility Location Address State or Province | 1 | 32 | professional:  837/2310C/N4/02;  institutional:  837/2310E/N4/02 |
| MC091 | Service Facility Location Address Zip Code | 1 | 32 | professional:  837/2310C/N4/03;  institutional:  837/2310E/N4/03 |
| MC092 | Service Facility Number | 57 | 32b | professional:  837/2310C/REF/G2/02;  institutional:  837/2310E /REF/G2/02 |
| MC093 | Service Facility Location Country Code | (1) | (32) | professional:  837/2310C/N4/04;  institutional:  837/2310E/N4/04 |
| MC094 | Billing Provider Country Code | (1) | (33) | 837/2010AA/N4/04 |
| MC101 | Subscriber Last Name | 58(A-C) | 4 | 837/2010BA/NM1/ /03 |
| MC102 | Subscriber First Name | 58(A-C) | 4 | 837/2010BA/NM1/ /04 |
| MC103 | Subscriber Middle Name | N/A | 4 | 837/2010BA/NM1/ /05 |
| MC104 | Member Last Name | 8b | 2 | 837/2010CA/NM1/ /03, 837/2010BA/NM1/ /03 |
| MC105 | Member First Name | 8b | 2 | 837/2010CA/NM1/ /04, 837/2010BA/NM1/ /04 |
| MC106 | Member Middle Name | 8b | 2 | 837/2010CA/NM1/ /05, 837/2010BA/NM1/ /05 |
| MC107 | Attending Provider Number | N/A | N/A | professional: N/A  institutional:  837/2310A/REF/G2/02 |
| MC108 | National Provider ID – Attending Provider | 76 | N/A | 837/2310A/NM1/71/1/XX/09 |
| MC109 | Attending Provider First Name | 76 | N/A | 837/2310A/NM1/71/1/04 |
| MC110 | Attending Provider Middle Name | N/A | N/A | 837/2310A/NM1/71/1/05 |
| MC111 | Attending Provider Last Name | 76 | N/A | 837/2310A/NM1/71/1/03 |
| MC112 | Attending Provider Suffix | N/A | N/A | 837/2310A/NM1/71/1/07 |
| MC113 | Attending Provider Specialty | N/A | N/A | 837/2310A/PRV/AT/PXC/03 |
| MC114 | Operating Provider Number | N/A | N/A | professional: N/A  institutional:  837/2310B/REF/G2/02; 837/2420A/REF/G2/02 |
| MC115 | National Provider ID – Operating Provider | 77 | N/A | professional: N/A  institutional:  837/2420A/NM1/72/1/XX/09; 837/2420A/NM1/72/1/XX/09 |
| MC116 | Operating Provider First Name | 77 | N/A | professional: N/A  institutional:  837/2420A/NM1/72/1/04; 837/2420A/NM1/72/1/04 |
| MC117 | Operating Provider Middle Name | N/A | N/A | professional: N/A  institutional:  837/2420A/NM1/72/1/05; 837/2420A/NM1/72/1/05 |
| MC118 | Operating Provider Last Name | 77 | N/A | professional: N/A  institutional:  837/2420A/NM1/72/1/03; 837/2420A/NM1/72/1/03 |
| MC119 | Operating Provider Suffix | N/A | N/A | professional: N/A  institutional:  837/2420A/NM1/72/1/07; 837/2420A/NM1/72/1/07 |
| MC120 | Referring Provider Number | N/A | N/A | professional:  837/2310A/REF/G2/02; 837/2420F/REF/G2/02  institutional:  837/2310F/REF/G2/02; 837/2420D/REF/G2/02 |
| MC121 | National Provider ID – Referring Provider | 78 or 79 | 17b | professional:  837/2310A/NM1/DN/1/XX/09; 837/2420F/NM1/DN/1/XX/09  institutional:  837/2310F/NM1/DN/1/XX/09; 837/2420D/NM1/DN/1/XX/09 |
| MC122 | Referring Provider First Name | 78 or 79 | 17 | professional:  837/2310A/NM1/DN/1/04; 837/2420F/NM1/DN/1/04  institutional:  837/2310F/NM1/DN/1/04; 837/2420D/NM1/DN/1/04 |
| MC123 | Referring Provider Middle Name | N/A | 17 | professional:  837/2310A/NM1/DN/1/05; 837/2420F/NM1/DN/1/05  institutional:  837/2310F/NM1/DN/1/05; 837/2420D/NM1/DN/1/05 |
| MC124 | Referring Provider Last Name | 78 or 79 | 17 | professional:  837/2310A/NM1/DN/1/03; 837/2420F/NM1/DN/1/03  institutional:  837/2310F/NM1/DN/1/03; 837/2420D/NM1/DN/1/03 |
| MC125 | Referring Provider Suffix | N/A | 17 | professional:  837/2310A/NM1/DN/1/07; 837/2420F/NM1/DN/1/07  institutional:  837/2310F/NM1/DN/1/07; 837/2420D/NM1/DN/1/07 |
| MC200 | Principal Diagnosis | 67 | N/A | 837/2300/HI/ABK/01-2 |
| MC201 | Present On Admission Indicator | 67 (pos 8) | N/A | 837/2300/HI/01-9 |
| MC202 | Admitting Diagnosis | 69 | N/A | 837/2300/HI/ABJ/01-2 |
| MC203 | Reason for Visit Diagnosis - 1 | 70A | N/A | 837/2300/HI/APR/01-2 |
| MC204 | Reason for Visit Diagnosis - 2 | 70B | N/A | 837/2300/HI/APR/02-2 |
| MC205 | Reason for Visit Diagnosis - 3 | 70C | N/A | 837/2300/HI/APR/03-2 |
| MC206 | External Cause of Injury - 1 | 72A | N/A | 837/2300/HI/ABN/01-2 |
| MC207 | Present On Admission Indicator - 1 | 72A (pos 8) | N/A | 837/2300/HI/01-9 |
| MC208 | External Cause of Injury - 2 | 72B | N/A | 837/2300/HI/ABN/02-2 |
| MC209 | Present On Admission Indicator - 2 | 72B (pos 8) | N/A | 837/2300/HI/02-9 |
| MC210 | External Cause of Injury - 3 | 72C | N/A | 837/2300/HI/ABN/03-2 |
| MC211 | Present On Admission Indicator - 3 | 72C (pos 8) | N/A | 837/2300/HI/03-9 |
| MC212 | External Cause of Injury - 4 | N/A | N/A | 837/2300/HI/ABN/04-2 |
| MC213 | Present On Admission Indicator - 4 | N/A | N/A | 837/2300/HI/04-9 |
| MC214 | External Cause of Injury - 5 | N/A | N/A | 837/2300/HI/ABN/05-2 |
| MC215 | Present On Admission Indicator - 5 | N/A | N/A | 837/2300/HI/05-9 |
| MC216 | External Cause of Injury - 6 | N/A | N/A | 837/2300/HI/ABN/06-2 |
| MC217 | Present On Admission Indicator - 6 | N/A | N/A | 837/2300/HI/06-9 |
| MC218 | External Cause of Injury - 7 | N/A | N/A | 837/2300/HI/ABN/07-2 |
| MC219 | Present On Admission Indicator - 7 | N/A | N/A | 837/2300/HI/07-9 |
| MC220 | External Cause of Injury - 8 | N/A | N/A | 837/2300/HI/ABN/08-2 |
| MC221 | Present On Admission Indicator - 8 | N/A | N/A | 837/2300/HI/08-9 |
| MC222 | External Cause of Injury - 9 | N/A | N/A | 837/2300/HI/ABN/09-2 |
| MC223 | Present On Admission Indicator - 9 | N/A | N/A | 837/2300/HI/09-9 |
| MC224 | External Cause of Injury - 10 | N/A | N/A | 837/2300/HI/ABN/10-2 |
| MC225 | Present On Admission Indicator - 10 | N/A | N/A | 837/2300/HI/10-9 |
| MC226 | External Cause of Injury - 11 | N/A | N/A | 837/2300/HI/ABN/11-2 |
| MC227 | Present On Admission Indicator - 11 | N/A | N/A | 837/2300/HI/11-9 |
| MC228 | External Cause of Injury - 12 | N/A | N/A | 837/2300/HI/ABN/12-2 |
| MC229 | Present On Admission Indicator - 12 | N/A | N/A | 837/2300/HI/12-9 |
| MC230 | External Cause of Injury - 13 | N/A | N/A | 837/2300/HI/ABN/01-2 |
| MC231 | Present On Admission Indicator - 13 | N/A | N/A | 837/2300/HI/01-9 |
| MC232 | External Cause of Injury - 14 | N/A | N/A | 837/2300/HI/ABN/02-2 |
| MC233 | Present On Admission Indicator - 14 | N/A | N/A | 837/2300/HI/02-9 |
| MC234 | External Cause of Injury - 15 | N/A | N/A | 837/2300/HI/ABN/03-2 |
| MC235 | Present On Admission Indicator - 15 | N/A | N/A | 837/2300/HI/03-9 |
| MC236 | External Cause of Injury - 16 | N/A | N/A | 837/2300/HI/ABN/04-2 |
| MC237 | Present On Admission Indicator - 16 | N/A | N/A | 837/2300/HI/04-9 |
| MC238 | External Cause of Injury - 17 | N/A | N/A | 837/2300/HI/ABN/05-2 |
| MC239 | Present On Admission Indicator - 17 | N/A | N/A | 837/2300/HI/05-9 |
| MC240 | External Cause of Injury - 18 | N/A | N/A | 837/2300/HI/ABN/06-2 |
| MC241 | Present On Admission Indicator - 18 | N/A | N/A | 837/2300/HI/06-9 |
| MC242 | External Cause of Injury - 19 | N/A | N/A | 837/2300/HI/ABN/07-2 |
| MC243 | Present On Admission Indicator - 19 | N/A | N/A | 837/2300/HI/07-9 |
| MC244 | External Cause of Injury - 20 | N/A | N/A | 837/2300/HI/ABN/08-2 |
| MC245 | Present On Admission Indicator - 20 | N/A | N/A | 837/2300/HI/08-9 |
| MC246 | External Cause of Injury - 21 | N/A | N/A | 837/2300/HI/ABN/09-2 |
| MC247 | Present On Admission Indicator - 21 | N/A | N/A | 837/2300/HI/09-9 |
| MC248 | External Cause of Injury - 22 | N/A | N/A | 837/2300/HI/ABN/10-2 |
| MC249 | Present On Admission Indicator - 22 | N/A | N/A | 837/2300/HI/10-9 |
| MC250 | External Cause of Injury - 23 | N/A | N/A | 837/2300/HI/ABN/11-2 |
| MC251 | Present On Admission Indicator - 23 | N/A | N/A | 837/2300/HI/11-9 |
| MC252 | External Cause of Injury - 24 | N/A | N/A | 837/2300/HI/ABN/12-2 |
| MC253 | Present On Admission Indicator - 24 | N/A | N/A | 837/2300/HI/12-9 |
| MC254 | Other Diagnosis – 1 | 67A | 21A | 837/2300/HI/ABF/01-2 |
| MC255 | Present On Admission Indicator – 1 | 67A (pos 8) | N/A | 837/2300/HI/01-9 |
| MC256 | Other Diagnosis – 2 | 67B | 21B | 837/2300/HI/ABF/02-2 |
| MC257 | Present On Admission Indicator – 2 | 67B (pos 8) | N/A | 837/2300/HI/02-9 |
| MC258 | Other Diagnosis – 3 | 67C | 21C | 837/2300/HI/ABF/03-2 |
| MC259 | Present On Admission Indicator – 3 | 67C (pos 8) | N/A | 837/2300/HI/03-9 |
| MC260 | Other Diagnosis – 4 | 67D | 21D | 837/2300/HI/ABF/04-2 |
| MC261 | Present On Admission Indicator – 4 | 67D (pos 8) | N/A | 837/2300/HI/04-9 |
| MC262 | Other Diagnosis – 5 | 67E | 21E | 837/2300/HI/ABF/05-2 |
| MC263 | Present On Admission Indicator – 5 | 67E (pos 8) | N/A | 837/2300/HI/05-9 |
| MC264 | Other Diagnosis – 6 | 67F | 21F | 837/2300/HI/ABF/06-2 |
| MC265 | Present On Admission Indicator – 6 | 67F (pos 8) | N/A | 837/2300/HI/06-9 |
| MC266 | Other Diagnosis – 7 | 67G | 21G | 837/2300/HI/ABF/07-2 |
| MC267 | Present On Admission Indicator – 7 | 67G (pos 8) | N/A | 837/2300/HI/07-9 |
| MC268 | Other Diagnosis – 8 | 67H | 21H | 837/2300/HI/ABF/08-2 |
| MC269 | Present On Admission Indicator – 8 | 67H (pos 8) | N/A | 837/2300/HI/08-9 |
| MC270 | Other Diagnosis – 9 | 67I | 21I | 837/2300/HI/ABF/09-2 |
| MC271 | Present On Admission Indicator – 9 | 67I (pos 8) | N/A | 837/2300/HI/09-9 |
| MC272 | Other Diagnosis – 10 | 67J | 21J | 837/2300/HI/ABF/10-2 |
| MC273 | Present On Admission Indicator – 10 | 67J (pos 8) | N/A | 837/2300/HI/10-9 |
| MC274 | Other Diagnosis – 11 | 67K | 21K | 837/2300/HI/ABF/11-2 |
| MC275 | Present On Admission Indicator – 11 | 67K (pos 8) | N/A | 837/2300/HI/11-9 |
| MC276 | Other Diagnosis – 12 | 67L | 21L | 837/2300/HI/ABF/12-2 |
| MC277 | Present On Admission Indicator – 12 | 67L (pos 8) | N/A | 837/2300/HI/12-9 |
| MC278 | Other Diagnosis – 13 | N/A | N/A | 837/2300/HI/ABF/01-2 |
| MC279 | Present On Admission Indicator – 13 | N/A | N/A | 837/2300/HI/01-9 |
| MC280 | Other Diagnosis – 14 | N/A | N/A | 837/2300/HI/ABF/02-2 |
| MC281 | Present On Admission Indicator – 14 | N/A | N/A | 837/2300/HI/02-9 |
| MC282 | Other Diagnosis – 15 | N/A | N/A | 837/2300/HI/ABF/03-2 |
| MC283 | Present On Admission Indicator – 15 | N/A | N/A | 837/2300/HI/03-9 |
| MC284 | Other Diagnosis – 16 | N/A | N/A | 837/2300/HI/ABF/04-2 |
| MC285 | Present On Admission Indicator – 16 | N/A | N/A | 837/2300/HI/04-9 |
| MC286 | Other Diagnosis – 17 | N/A | N/A | 837/2300/HI/ABF/05-2 |
| MC287 | Present On Admission Indicator – 17 | N/A | N/A | 837/2300/HI/05-9 |
| MC288 | Other Diagnosis – 18 | N/A | N/A | 837/2300/HI/ABF/06-2 |
| MC289 | Present On Admission Indicator – 18 | N/A | N/A | 837/2300/HI/06-9 |
| MC290 | Other Diagnosis – 19 | N/A | N/A | 837/2300/HI/ABF/07-2 |
| MC291 | Present On Admission Indicator – 19 | N/A | N/A | 837/2300/HI/07-9 |
| MC292 | Other Diagnosis – 20 | N/A | N/A | 837/2300/HI/ABF/08-2 |
| MC293 | Present On Admission Indicator – 20 | N/A | N/A | 837/2300/HI/08-9 |
| MC294 | Other Diagnosis – 21 | N/A | N/A | 837/2300/HI/ABF/09-2 |
| MC295 | Present On Admission Indicator – 21 | N/A | N/A | 837/2300/HI/09-9 |
| MC296 | Other Diagnosis – 22 | N/A | N/A | 837/2300/HI/ABF/10-2 |
| MC297 | Present On Admission Indicator – 22 | N/A | N/A | 837/2300/HI/10-9 |
| MC298 | Other Diagnosis – 23 | N/A | N/A | 837/2300/HI/ABF/11-2 |
| MC299 | Present On Admission Indicator – 23 | N/A | N/A | 837/2300/HI/11-9 |
| MC300 | Other Diagnosis – 24 | N/A | N/A | 837/2300/HI/ABF/12-2 |
| MC301 | Present On Admission Indicator – 24 | N/A | N/A | 837/2300/HI/12-9 |
| MC302 | Principal Procedure Code | 74 | N/A | 837/2300/HI/BBR/01-2 |
| MC303 | Other Procedure Code - 1 | 74A | N/A | 837/2300/HI/BBQ/01-2 |
| MC304 | Other Procedure Code - 2 | 74B | N/A | 837/2300/HI/BBQ/02-2 |
| MC305 | Other Procedure Code - 3 | 74C | N/A | 837/2300/HI/BBQ/03-2 |
| MC306 | Other Procedure Code - 4 | 74D | N/A | 837/2300/HI/BBQ/04-2 |
| MC307 | Other Procedure Code - 5 | 74E | N/A | 837/2300/HI/BBQ/05-2 |
| MC308 | Other Procedure Code - 6 | N/A | N/A | 837/2300/HI/BBQ/06-2 |
| MC309 | Other Procedure Code - 7 | N/A | N/A | 837/2300/HI/BBQ/07-2 |
| MC310 | Other Procedure Code - 8 | N/A | N/A | 837/2300/HI/BBQ/08-2 |
| MC311 | Other Procedure Code - 9 | N/A | N/A | 837/2300/HI/BBQ/09-2 |
| MC312 | Other Procedure Code - 10 | N/A | N/A | 837/2300/HI/BBQ/10-2 |
| MC313 | Other Procedure Code - 11 | N/A | N/A | 837/2300/HI/BBQ/11-2 |
| MC314 | Other Procedure Code - 12 | N/A | N/A | 837/2300/HI/BBQ/12-2 |
| MC315 | Other Procedure Code - 13 | N/A | N/A | 837/2300/HI/BBQ/01-2 |
| MC316 | Other Procedure Code - 14 | N/A | N/A | 837/2300/HI/BBQ/02-2 |
| MC317 | Other Procedure Code - 15 | N/A | N/A | 837/2300/HI/BBQ/03-2 |
| MC318 | Other Procedure Code - 16 | N/A | N/A | 837/2300/HI/BBQ/04-2 |
| MC319 | Other Procedure Code - 17 | N/A | N/A | 837/2300/HI/BBQ/05-2 |
| MC320 | Other Procedure Code - 18 | N/A | N/A | 837/2300/HI/BBQ/06-2 |
| MC321 | Other Procedure Code - 19 | N/A | N/A | 837/2300/HI/BBQ/07-2 |
| MC322 | Other Procedure Code - 20 | N/A | N/A | 837/2300/HI/BBQ/08-2 |
| MC323 | Other Procedure Code - 21 | N/A | N/A | 837/2300/HI/BBQ/09-2 |
| MC324 | Other Procedure Code - 22 | N/A | N/A | 837/2300/HI/BBQ/10-2 |
| MC325 | Other Procedure Code - 23 | N/A | N/A | 837/2300/HI/BBQ/11-2 |
| MC326 | Other Procedure Code - 24 | N/A | N/A | 837/2300/HI/BBQ/12-2 |
| MC327 | Member Address Line 1 | 9a | 5 | 837/2010BA/N3/01, 837/2010CA/N3/01 |
| MC328 | Member Address Line 2 | 9a | 5 | 837/2010BA/N3/02, 837/2010CA/N3/02 |
| MC329 | Member Country Code | 9e | N/A | 837/2010BA/N4/04, 837/2010CA/N4/04 |
| MC330 | In-Plan Network Indicator | N/A | N/A | N/A |
| MC899 | Record Type | N/A | N/A | N/A |

| **Data Element**  **#** | **Data Element Name** | Date **Effective** | **Type** | **Maximum Length** | **Description/Codes/Sources** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| **PC001** | **Submitter** | 1/1/2003 | Text | 8 | MHDO-assigned identifier of payer submitting claims  data. Do not leave blank. |
|  |  |  |  |  |  |
| **PC002** | **Payer** | 7/1/2012 | Text | 8 | MHDO-assigned code of the insurer/underwriter in the  case of premiums-based coverage, or of the administrator in the case  of self-funded coverage. Do not leave blank. |
|  |  |  |  |  |  |
| **PC003** | **Insurance Type/Product Code** | 1/1/2003 | Text | 2 | Code identifying the type of insurance policy within a specific insurance program. Refer to Appendix A |
|  |  |  |  |  | 16 Medicare Part C |
|  |  |  |  |  | MD Medicare Part D |
|  |  |  |  |  | SP Supplemental Policy |
|  |  |  |  |  |  |
| **PC004** | **Payer Claim Control Number** | 1/1/2003 | Text | 35 | Must apply to the entire claim and be unique within the payer's system. |
|  |  |  |  |  |  |
| **PC005** | **Line Counter** | 4/1/2004 | Number | 4 | Line number for this service |
|  |  |  |  |  | The line counter begins with 1 and is incremented by 1 for each  additional service line of a claim. |
|  |  |  |  |  |  |
| **PC006** | **Insured Group or Policy Number** | 1/1/2003 | Text | 30 | Group or policy number - not the number that uniquely identifies the |
|  |  |  |  |  | subscriber |
|  |  |  |  |  |  |
| **PC007** | **Subscriber Social Security Number** | 1/1/2003 | Text | 9 | Subscriber’s social security number  Leave blank if unavailable. |
|  |  |  |  |  |  |
| **PC008** | **Plan Specific Contract Number** | 1/1/2003 | Text | 80 | Plan assigned contract number |
|  |  |  |  |  | Leave blank if contract number = subscriber’s social security number. |
|  |  |  |  |  |  |
| **PC009** | **Member Suffix or Sequence Number** | 1/1/2003 | Text | 20 | Uniquely numbers the member within the contract |
|  |  |  |  |  |  |
| **PC010** | **Member Identification Code** | 1/1/2003 | Text | 50 | Member’s social security number  Leave blank if unavailable |
|  |  |  |  |  |  |
| **PC011** | **Individual Relationship Code** | 1/1/2003 | Text | 2 | Member's relationship to insured  Refer to Appendix A |
|  |  |  |  |  |  |
| **PC012** | **Member Gender** | 1/1/2003 | Number | 1 | Refer to Appendix A |
| **PC013** | **Member Date of Birth** | 1/1/2003 | Text | 8 | CCYYMMDD |
|  |  |  |  |  |  |
| **PC014** | **Member City Name** | 4/1/2004 | Text | 30 | City name of member  Refer to Appendix A |
|  |  |  |  |  |  |
| **PC015** | **Member State or Province** | 4/1/2004 | Text | 2 | As defined by the US Postal Service and Canada Post  Refer to Appendix A |
|  |  |  |  |  |  |
| **PC016** | **Member ZIP Code** | 1/1/2003 | Text | 11 | ZIP Code of member - may include non-US codes  Do not include dash  Refer to Appendix A |
|  |  |  |  |  |  |
| **PC017** | **Date Service Approved (AP Date)** | 1/1/2003 | Text | 8 | CCYYMMDD |
|  |  |  |  |  |  |
| **PC018** | **Pharmacy Number** | 1/1/2003 | Text | 30 | Payer assigned pharmacy number |
|  |  |  |  |  | AHFS number is acceptable. |
|  |  |  |  |  |  |
| **PC019** | **Pharmacy Tax ID Number** | 1/1/2003 | Text | 10 | Federal taxpayer's identification number |
|  |  |  |  |  |  |
| **PC020** | **Pharmacy Name** | 1/1/2003 | Text | 100 | Name of pharmacy |
|  |  |  |  |  |  |
| **PC021** | **National Provider ID – Pharmacy Provider** | 4/1/2004 | Text | 20 | National Provider ID for Pharmacy  This data element pertains to the entity or individual directly providing  the service.  Refer to Appendix A |
|  |  |  |  |  |  |
| **PC022** | **Pharmacy Location City** | 4/1/2004 | Text | 30 | City name of pharmacy - preferably pharmacy location  Refer to Appendix A |
|  |  |  |  |  |  |
| **PC023** | **Pharmacy Location State** | 4/1/2004 | Text | 2 | As defined by the US Postal Service and Canada Post  Refer to Appendix A |
|  |  |  |  |  |  |
| **PC024** | **Pharmacy ZIP Code** | 1/1/2003 | Text | 11 | ZIP Code of pharmacy - may include non-US codes  Do not include dash.  Refer to Appendix A |
|  |  |  |  |  |  |
| **PC024A** | **Pharmacy Country Code** | 1/1/2010 | Text | 30 | Use ISO 3166-1 alpha-2 country codes. Refer to Appendix A. |
|  |  |  |  |  |  |
| **PC025** | **Claim Status** | 1/1/2003 | Text | 2 | Refer to Appendix A |
|  |  |  |  |  |  |
| **PC026** | **Drug Code** | 1/1/2003 | Text | 11 | NDC Code  Refer to Appendix A |
|  |  |  |  |  |  |
| **PC027** | **Drug Name** | 1/1/2003 | Text | 80 | Text name of drug |
|  |  |  |  |  |  |
| **PC028** | **New Prescription or Refill** | 1/1/2003 | Text | 2 | 00 New prescription |
|  |  |  |  |  | 01-99 Number of refill |
|  |  |  |  |  |  |
| **PC029** | **Generic Drug Indicator** | 1/1/2003 | Text | 1 | N No, branded drug |
|  |  |  |  |  | Y Yes, generic drug |
|  |  |  |  |  |  |
| **PC030** | **Dispense as Written Code** | 1/1/2003 | Text | 1 | Refer to Appendix A |
|  |  |  |  |  |  |
| **PC031** | **Compound Drug Indicator** | 4/1/2004 | Text | 1 | N Non-compound drug |
|  |  |  |  |  | U Non-specified drug compound |
|  |  |  |  |  | Y Compound drug |
|  |  |  |  |  |  |
| **PC032** | **Date Prescription Filled** | 1/1/2003 | Text | 8 | CCYYMMDD |
|  |  |  |  |  |  |
| **PC033** | **Quantity Dispensed** | 1/1/2003 | Number | 10 | Number of metric units of medication dispensed. Code decimal point. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **PC034** | **Days’ Supply** | 1/1/2003 | Number | 3 | Estimated number of days the prescription will last |
|  |  |  |  |  |  |
| **PC035** | **Charge Amount** | 1/1/2003 | Number | 10 | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **PC036** | **Paid Amount** | 1/1/2003 | Number | 10 | Includes all health plan payments and excludes all member payments |
|  |  |  |  |  | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **PC037** | **Ingredient Cost/List Price** | 1/1/2003 | Number | 10 | Cost of the drug dispensed  Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **PC038** | **Postage Amount Claimed** | 4/1/2004 | Number | 10 | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **PC039** | **Dispensing Fee** | 1/1/2003 | Number | 10 | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **PC040** | **Co-pay Amount** | 1/1/2003 | Number | 10 | The preset, fixed dollar amount for which the individual is responsible |
|  |  |  |  |  | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **PC041** | **Coinsurance Amount** | 1/1/2003 | Number | 10 | The dollar amount an individual is responsible for – not the percentage  Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **PC042** | **Deductible Amount** | 1/1/2003 | Number | 10 | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **PC043** | **Patient Pay Amount** | 1/1/2013 | Number | 10 | Amount that is calculated by the payer and returned to the pharmacy as  the total amount to be paid by the patient to the pharmacy. $0 is  acceptable; if “data not available” leave blank.  Do not include decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **PC044** | **Prescribing Physician First Name** | 7/1/2006 | Text | 40 | Physician first name  Optional if PC047 is filled. |
|  |  |  |  |  |  |
| **PC045** | **Prescribing Physician Middle Name** | 7/1/2006 | Text | 25 | Physician middle name or initial  Optional if PC047 is filled. |
|  |  |  |  |  |  |
| **PC046** | **Prescribing Physician Last Name** | 7/1/2006 | Text | 60 | Physician last name. Optional if PC047 is filled. |
|  |  |  |  |  |  |
| **PC047** | **Prescribing Physician DEA** | 7/1/2006 | Text | 20 | DEA for prescribing physician |
|  |  |  |  |  |  |
| **PC048** | **Prescribing Physician NPI** | 10/1/2014 | Text | 20 | NPI for prescribing physician  Refer to Appendix A |
|  |  |  |  |  |  |
| **PC101** | **Subscriber Last Name** | 1/1/2010 | Text | 60 | The subscriber last name |
|  |  |  |  |  |  |
| **PC102** | **Subscriber First Name** | 1/1/2010 | Text | 35 | The subscriber first name |
|  |  |  |  |  |  |
| **PC103** | **Subscriber Middle Name** | 1/1/2010 | Text | 25 | The subscriber middle name or initial |
|  |  |  |  |  |  |
| **PC104** | **Member Last Name** | 1/1/2010 | Text | 60 | The member last name |
|  |  |  |  |  |  |
| **PC105** | **Member First Name** | 1/1/2010 | Text | 35 | The member first name |
|  |  |  |  |  |  |
| **PC106** | **Member Middle Name** | 1/1/2010 | Text | 25 | The member middle name or initial |
|  |  |  |  |  |  |
| **PC107** | **Member Address Line 1** | 2/1/2019 | Text | 55 |  |
|  |  |  |  |  |  |
| **PC108** | **Member Address Line 2** | 2/1/2019 | Text | 55 |  |
|  |  |  |  |  |  |
| **PC109** | **Member Country Code** | 2/1/2019 | Text | 2 | Use ISO 3166-1 alpha-2 country codes. Refer to Appendix A. |
|  |  |  |  |  |  |
| **PC110** | **In-Plan Network Indicator** | 2/1/2021 | Text | 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. |
|  |  |  |  |  |  |
| **PC899** | **Record Type** | 1/1/2003 | Text | 2 | PC |

| **Data**  **Element #** | **Data Element Name** | **National Council for Prescription** |
| --- | --- | --- |
| **Drug Programs Field #** |
| PC001 | Submitter | 879-N2 |
| PC002 | Payer | 569-J8 |
| PC003 | Insurance Type/Product Code | A90 |
| PC004 | Payer Claim Control Number | 993-A7 |
| PC005 | Line Counter | A91 |
| PC006 | Insured Group or Policy Number | 246 |
| PC007 | Subscriber Social Security Number | A89 |
| PC008 | Plan Specific Contract Number | 302-C2 |
| PC009 | Member Suffix or Sequence Number | 303-C3 |
| PC010 | Member Identification Code | 332-CY |
| PC011 | Individual Relationship Code | 247 |
| PC012 | Member Gender | 305-C5 |
| PC013 | Member Date of Birth | 304-C4 |
| PC014 | Member City Name | 728-SU |
| PC015 | Member State or Province | 729-TA |
| PC016 | Member ZIP Code | 730-TC |
| PC017 | Date Service Approved (AP Date) | 578 |
| PC018 | Pharmacy Number | 201-B1 |
| PC019 | Pharmacy Tax ID Number | N/A |
| PC020 | Pharmacy Name | 833-5P |
| PC021 | National Provider ID – Pharmacy Provider | 201-B1 |
| PC022 | Pharmacy Location City | 728-SU |
| PC023 | Pharmacy Location State | 729-TA |
| PC024 | Pharmacy ZIP Code | 730-TC |
| PC024A | Pharmacy Country Code | A93-1T |
| PC025 | Claim Status | A88 |
| PC026 | Drug Code | 407-D7 |
| PC027 | Drug Name | 397 |
| PC028 | New Prescription | 254 |
| **Data**  **Element #** | **Data Element Name** | **National Council for Prescription Drug Programs Field #** |
| PC029 | Generic Drug Indicator | 425-DP |
| PC030 | Dispense as Written Code | 408-D8 |
| PC031 | Compound Drug Indicator | 406-D6 |
| PC032 | Date Prescription Filled | 401-D1 |
| PC033 | Quantity Dispensed | 442-E7 |
| PC034 | Days’ Supply | 405-D5 |
| PC035 | Charge Amount | 430-DU |
| PC036 | Paid Amount | 281 |
| PC037 | Ingredient Cost/List Price | 506-F6 |
| PC038 | Postage Amount Claimed | N/A |
| PC039 | Dispensing Fee | 507-F7 |
| PC040 | Co-pay Amount | 518-FI |
| PC041 | Coinsurance Amount | 572-4U |
| PC042 | Deductible Amount | 517-FH |
| PC043 | Patient Pay Amount | 505-F5 |
| PC044 | Prescribing Physician First Name | 717 |
| PC045 | Prescribing Physician Middle Name | A92 |
| PC046 | Prescribing Physician Last Name | 716 |
| PC047 | Prescribing Physician DEA | 411-DB |
| PC048 | Prescribing Physician NPI | 411-DB |
| PC101 | Subscriber Last Name | 716 |
| PC102 | Subscriber First Name | 717 |
| PC103 | Subscriber Middle Name | 718 |
| PC104 | Member Last Name | 716 |
| PC105 | Member First Name | 717 |
| PC106 | Member Middle Name | 718 |
| PC107 | Member Address Line 1 | B08-7A |
| PC108 | Member Address Line 2 | B09-7B |
| PC109 | Member Country Code | A43-1K |
| PC110 | In-Plan Network Indicator | N/A |
| PC899 | Record Type | A94 |

| **Data Element** |  | Date |  | **Maximum** |  |
| --- | --- | --- | --- | --- | --- |
| **#** | **Data Element Name** | **Effective** | **Type** | **Length** | **Description/Codes/Sources** |
|  |  |  |  |  |  |
| **DC001** | **Submitter** | 1/1/2003 | Text | 8 | MHDO-assigned identifier of payer submitting  claims data. Do not leave blank. |
|  |  |  |  |  |  |
| **DC002** | **Payer** | 7/1/2012 | Text | 8 | MHDO-assigned code of the insurer/  underwriter in the case of premiums-based coverage, or of  the administrator in the case of self-funded coverage.  Do not leave blank. |
|  |  |  |  |  |  |
| **DC003** | **Insurance Type/Product Code** | 1/1/2003 | Text | 2 | Code identifying the type of insurance policy within a specific insurance program. Refer to Appendix A |
|  |  |  |  |  |  |
| **DC004** | **Payer Claim Control Number** | 1/1/2003 | Text | 35 | Must apply to entire claim and be unique within the payer's  system |
|  |  |  |  |  |  |
| **DC005** | **Line Counter** | 4/1/2004 | Number | 4 | Line number for this service  The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. |
|  |  |  |  |  |  |
| **DC006** | **Insured Group or Policy Number** | 1/1/2003 | Text | 30 | Group or policy number - not the number that uniquely  identifies the subscriber |
|  |  |  |  |  |  |
| **DC007** | **Subscriber Social Security Number** | 1/1/2003 | Text | 9 | Subscriber’s social security number  Leave blank if unavailable. |
|  |  |  |  |  |  |
| **DC008** | **Plan Specific Contract Number** | 1/1/2003 | Text | 80 | Plan assigned contract number  Leave blank if contract number = subscriber’s social security  number. |
|  |  |  |  |  |  |
| **DC009** | **Member Suffix or Sequence Number** | 1/1/2003 | Text | 20 | Uniquely numbers the member within the contract |
|  |  |  |  |  |  |
| **DC010** | **Member Identification Code** | 1/1/2003 | Text | 50 | Member’s social security number  Leave blank if unavailable. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **DC011** | **Individual Relationship Code** | 1/1/2003 | Text | 2 | Member's relationship to insured  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC012** | **Member Gender** | 1/1/2003 | Text | 1 | Refer to Appendix A |
|  |  |  |  |  |  |
| **DC013** | **Member Date of Birth** | 1/1/2003 | Text | 8 | CCYYMMDD |
|  |  |  |  |  |  |
| **DC014** | **Member City Name** | 4/1/2004 | Text | 30 | City name of member  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC015** | **Member State or Province** | 4/1/2004 | Text | 2 | As defined by the US Postal Service and Canada Post  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC016** | **Member ZIP Code** | 1/1/2003 | Text | 11 | ZIP Code of member - may include non-US codes  Do not include dash.  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC017** | **Date Service Approved (AP Date)** | 1/1/2003 | Text | 8 | CCYYMMDD |
|  |  |  |  |  |  |
| **DC018** | **Rendering Provider Number** | 1/1/2003 | Text | 30 | Payer assigned provider number |
|  |  |  |  |  |  |
| **DC019** | **Rendering Provider Tax ID Number** | 1/1/2003 | Text | 10 | Federal taxpayer's identification number |
|  |  |  |  |  |  |
| **DC020** | **National Provider ID – Rendering Provider** | 4/1/2004 | Text | 20 | National Provider ID  This data element pertains to the entity or individual directly  providing the service.  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC021** | **Rendering Provider Entity Type Qualifier** | 4/1/2004 | Number | 1 | HIPAA provider taxonomy classifies provider groups (clinicians  who bill as a group practice or under a corporate name, even if  that group is composed of one provider) as a “person”, and  these shall be coded as a person. |
|  |  |  |  |  | Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **DC022** | **Rendering Provider First Name** | 1/1/2003 | Text | 40 | Individual first name  Leave blank if provider is a facility or organization. |
|  |  |  |  |  |  |
| **DC023** | **Rendering Provider Middle Name** | 1/1/2003 | Text | 25 | Individual middle name or initial  Leave blank if provider is a facility or organization. |
|  |  |  |  |  |  |
| **DC024** | **Rendering Provider Last Name or Organization Name** | 1/1/2003 | Text | 60 | Full name of provider organization or last name of individual  provider |
|  |  |  |  |  |  |
| **DC025** | **Rendering Provider Suffix** | 1/1/2003 | Text | 10 | Suffix to individual name  Leave blank if provider is a facility or organization.  The service provider suffix shall be used to capture the  generation of the individual clinician (e.g., Jr., Sr., III), if  applicable, rather than the clinician’s degree (e.g., MD, LCSW). |
|  |  |  |  |  |  |
| **DC026** | **Rendering Provider Specialty** | 1/1/2003 | Text | 10 | Refer to Appendix A  If defined by payer, then dictionary for specialty code values  must be supplied during testing. |
|  |  |  |  |  |  |
| **DC027** | **Placeholder** | 2/1/2016 | N/A | 0 | Leave blank  Service Provider City Name retired; refer to DC055 –  Service Facility Location City Name |
|  |  |  |  |  |  |
| **DC028** | **Placeholder** | 2/1/2016 | N/A | 0 | Leave blank  Service Provider State or Province retired; refer to  DC056 – Service Facility Location Address State or  Province |
|  |  |  |  |  |  |
| **DC029** | **Placeholder** | 2/1/2016 | N/A | 0 | Leave blank  Service Provider ZIP Code retired; refer to DC057 –  Service Facility Location Address State or Province |
|  |  |  |  |  |  |
| **DC030** | **Place of Service - Professional** | 4/1/2004 | Text | 2 | Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **DC031** | **Claim Status** | 1/1/2003 | Text | 2 | Refer to Appendix A |
|  |  |  |  |  |  |
| **DC032** | **CDT Code** | 1/1/2003 | Text | 5 | Common Dental Terminology code  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC033** | **Procedure Modifier - 1** | 1/1/2003 | Text | 2 | Procedure modifier required when a modifier clarifies/improves  the reporting accuracy of the associated procedure code |
|  |  |  |  |  |  |
| **DC034** | **Procedure Modifier - 2** | 1/1/2003 | Text | 2 | Procedure modifier required when a modifier clarifies/improves  the reporting accuracy of the associated procedure code |
|  |  |  |  |  |  |
| **DC035** | **Date of Service - From** | 1/1/2003 | Text | 8 | First date of service for this service line  CCYYMMDD |
|  |  |  |  |  |  |
| **DC036** | **Date of Service - Thru** | 1/1/2003 | Text | 8 | Last date of service for this service line  CCYYMMDD |
|  |  |  |  |  |  |
| **DC037** | **Charge Amount** | 1/1/2003 | Number | 10 | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **DC038** | **Paid Amount** | 1/1/2003 | Number | 10 | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **DC039** | **Co-pay Amount** | 1/1/2003 | Number | 10 | The preset, fixed dollar amount for which the individual  is responsible  Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **DC040** | **Coinsurance Amount** | 1/1/2003 | Number | 10 | The dollar amount an individual is responsible for – not the percentage  Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **DC041** | **Deductible Amount** | 1/1/2003 | Number | 10 | Do not code decimal point. Two decimal places implied. |
|  |  |  |  |  |  |
| **DC042** | **Billing Provider Number** | 1/1/2010 | Text | 30 | Payer assigned billing provider number. This number should  be the identifier used by the payer for internal identification  purposes, and does not routinely change. |
|  |  |  |  |  |  |
| **DC043** | **National Provider ID – Billing Provider** | 1/1/2010 | Text | 20 | National Provider ID for billing provider  Refer to Appendix A |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **DC044** | **Billing Provider Last Name or Organization Name** | 1/1/2010 | Text | 60 | Full name of provider billing organization or last name of  individual billing provider. |
|  |  |  |  |  |  |
| **DC045** | **Billing Provider Tax ID** | 2/1/2016 | Text | 10 | Federal taxpayer’s identification number |
|  |  |  |  |  |  |
| **DC046** | **Billing Provider Address Line 1** | 2/1/2016 | Text | 55 | Address information for billing provider |
|  |  |  |  |  |  |
| **DC047** | **Billing Provider Address Line 2** | 2/1/2016 | Text | 55 | Address information for billing provider |
|  |  |  |  |  |  |
| **DC048** | **Billing Provider City Name** | 2/1/2016 | Text | 30 | City name of billing provider  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC049** | **Billing Provider State or Province** | 2/1/2016 | Text | 2 | As defined by the US Postal Service and Canada Post  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC050** | **Billing Provider Zip Code** | 2/1/2016 | Text | 11 | Zip Code of billing provider – may include non-US codes  Do not include dash  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC051** | **Service Facility Location Name** | 2/1/2016 | Text | 60 | Laboratory or service facility name  If blank or not specified, populate with DC044 -- Billing  Provider Last Name or Organization Name. |
|  |  |  |  |  |  |
| **DC052** | **National Provider ID – Service Facility** | 2/1/2016 | Text | 20 | National Provider ID for laboratory or service facility  If blank or not specified, populate with DC043 -- National  Provider ID – Billing Provider. Refer to Appendix A |
|  |  |  |  |  |  |
| **DC053** | **Service Facility Location Address Line 1** | 2/1/2016 | Text | 55 | Address information for laboratory or service facility  If blank or not specified, populate with DC046 – Billing  Provider Address Line 1. |
|  |  |  |  |  |  |
| **DC054** | **Service Facility Location Address Line 2** | 2/1/2016 | Text | 55 | Address information for laboratory or service facility  If blank or not specified, populate with DC047– Billing  Provider Address Line 2. |
|  |  |  |  |  |  |
| **DC055** | **Service Facility Location City Name** | 2/1/2016 | Text | 30 | City name of laboratory or service facility  If blank or not specified, populate with DC048 -- Billing  Provider City Name.  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC056** | **Service Facility Location State or Province** | 2/1/2016 | Text | 2 | As defined by the US Postal Service and Canada Post  If blank or not specified, populate with DC049 -- Billing  Provider State or Province.  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC057** | **Service Facility Location Zip Code** | 2/1/2016 | Text | 11 | Zip Code of service facility – may include non-US codes  Do not include dash  If blank or not specified, populate with DC050 -- Billing  Provider Zip Code.  Refer to Appendix A |
|  |  |  |  |  |  |
| **DC058** | **Service Facility Number** | 2/1/2016 | Text | 30 | Payer assigned service facility number. This number  should be the identifier used by the payer for internal  identification purposes, and does not routinely change.  If blank or not specified, populate with DC042-- Billing  Provider Number. |
|  |  |  |  |  |  |
| **DC101** | **Subscriber Last Name** | 1/1/2010 | Text | 60 | The subscriber last name |
|  |  |  |  |  |  |
| **DC102** | **Subscriber First Name** | 1/1/2010 | Text | 35 | The subscriber first name |
|  |  |  |  |  |  |
| **DC103** | **Subscriber Middle Name** | 1/1/2010 | Text | 25 | The subscriber middle name or initial |
|  |  |  |  |  |  |
| **DC104** | **Member Last Name** | 1/1/2010 | Text | 60 | The member last name |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **DC105** | **Member First Name** | 1/1/2010 | Text | 35 | The member first name |
|  |  |  |  |  |  |
| **DC106** | **Member Middle Name** | 1/1/2010 | Text | 25 | The member middle name or initial |
|  |  |  |  |  |  |
| **DC107** | **Member Address Line 1** | 2/1/2019 | Text | 55 |  |
|  |  |  |  |  |  |
| **DC108** | **Member Address Line 2** | 2/1/2019 | Text | 55 |  |
|  |  |  |  |  |  |
| **DC109** | **Member Country Code** | 2/1/2019 | Text | 2 | Use ISO 3166-1 alpha-2 country codes. Refer to  Appendix A. |
|  |  |  |  |  |  |
| **DC110** | **In-Plan Network Indicator** | 2/1/2021 | Text | 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. |
|  |  |  |  |  |  |
| **DC899** | **Record Type** | 1/1/2003 | Text | 2 | DC |

|  |  |  | HIPAA Reference ASC X12N/005010A1 |
| --- | --- | --- | --- |
| **Data** |  | **ADA J400** | **Transaction Set/Loop/** |
| **Element** |  |  | **Segment ID/Code Value/** |
| **#** | **Data Element Name** | **Form Locator** | **Reference Designator** |
| DC001 | Submitter | N/A | N/A |
| DC002 | Payer | N/A | N/A |
| DC003 | Insurance Type/Product Code | N/A | 835/2100/CLP/06 |
| DC004 | Payer Claim Control Number | N/A | 835/2100/CLP/07 |
| DC005 | Line Counter | N/A | 837/2400/LX/01 |
| DC006 | Insured Group or Policy Number | 16 | 837/2000B/SBR/03 |
| DC007 | Subscriber Social Security Number | 15 | 837/2010BA/REF/SY/02 |
| DC008 | Plan Specific Contract Number | N/A | 835/2100/NM1/MI/08 |
| DC009 | Member Suffix or Sequence Number | N/A | N/A |
| DC010 | Member Identification Code | N/A | 835/2100/NM1/34/09 |
| DC011 | Individual Relationship Code | 18 | 837/2000B/SBR/02, 837/2000C/PAT/01 |
| DC012 | Member Gender | 22 | 837/2010BA/DMG/03, 837/2010CA/DMG/03 |
| DC013 | Member Date of Birth | 21 | 837/2010BA/DMG/D8/02, 837/2010CA/DMG/D8/02 |
| DC014 | Member City Name | 20 | 837/2010BA/N4/01, 837/2010CA/N4/01 |
| DC015 | Member State or Province | 20 | 837/2010BA/N4/02, 837/2010CA/N4/02 |
| DC016 | Member ZIP Code of Residence | 20 | 837/2010BA/N4/03, 837/2010CA/N4/03 |
| DC017 | Date Service Approved | N/A | 835/Header Financial Information/BPR/16 |
| DC018 | Rendering Provider Number | 58 | 835/2100/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, |
|  |  |  | 835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09 |
| DC019 | Rendering Provider Tax ID Number | 51 | 835/2100/NM1/FI/09 |
| DC020 | National Provider ID – Rendering Provider | 54 | 837/2310B/NM1/XX/09 |
| DC021 | Rendering Provider Entity Type Qualifier | N/A | 837/2310B/NM1/82/02 |
| DC022 | Rendering Provider First Name | N/A | 837/2310B/NM1/82/04 |
| DC023 | Rendering Provider Middle Name | N/A | 837/2310B/NM1/82/05 |
| DC024 | Rendering Provider Last Name or Organization Name | N/A | 837/2310B/NM1/82/03 |
| DC025 | Rendering Provider Suffix | N/A | 837/2310B/NM1/82/07 |
| DC026 | Rendering Provider Specialty | 56A | 837/2310B/PRV/PXC/03 |
| DC027 | Placeholder | N/A | N/A |
| DC028 | Placeholder | N/A | N/A |
| DC029 | Placeholder | N/A | N/A |
| DC030 | Place of Service - Professional | 38 | 837/2300/CLM/05-1 |
| DC031 | Claim Status | N/A | 835/2100/CLP/02 |
| DC032 | CDT Code | 29 | 837/2400/SV3/AD/01-2 |
| DC033 | Procedure Modifier - 1 | N/A | 837/2400/SV3/AD/01-3 |
| DC034 | Procedure Modifier - 2 | N/A | 837/2400/SV3/AD/01-4 |
| DC035 | Date of Service - From | 24 | 837/2400/DTP/472/D8/03, 837/2300/DTP/472/D8/03 |
| DC036 | Date of Service - Thru | 24 | 837/2400/DTP/472/D8/03, 837/2300/DTP/472/D8/03 |
| DC037 | Charge Amount | 31 | 837/2400/SV3/02 |
| DC038 | Paid Amount | N/A | 835/2110/SVC/03 |
| DC039 | Co-pay Amount | N/A | 835/2110/CAS/PR/3-03 |
| DC040 | Coinsurance Amount | N/A | 835/2110/CAS/PR/2-03 |
| DC041 | Deductible Amount | N/A | 835/2110/CAS/PR/1-03 |
| DC042 | Billing Provider Number | 52A | 837/2010BB/REF/G2/02 |
| DC043 | National Provider ID – Billing Provider | 49 | 837/2010AA/NM1/XX/09 |
| DC044 | Billing Provider Last Name | 48 | 837/2010AA/NM1/ /03 |
| DC045 | Billing Provider Tax ID | 51 | 837/2010AA/REF/EI/02 |
| DC046 | Billing Provider Address Line 1 | 48 | 837/2010AA/N3/01 |
| DC047 | Billing Provider Address Line 2 | 48 | 837/2010AA/N3/02 |
| DC048 | Billing Provider City Name | 48 | 837/2010AA/N4/01 |
| DC049 | Billing Provider State or Province | 48 | 837/2010AA/N4/02 |
| DC050 | Billing Provider Zip Code | 48 | 837/2010AA/N4/03 |
| DC051 | Service Facility Location Name | N/A | 837/2310C/NM1/77/2/03 |
| DC052 | National Provider ID – Service Facility | N/A | 837/2310C/NM1/77/2/XX/09 |
| DC053 | Service Facility Location Address Line 1 | 56 | 837/2310C/N3/01 |
| DC054 | Service Facility Location Address Line 2 | 56 | 837/2310C/N3/02 |
| DC055 | Service Facility Location City Name | 56 | 837/2310C/N4/01 |
| DC056 | Service Facility Location State or Province | 56 | 837/2310C/N4/02 |
| DC057 | Service Facility Location Zip Code | 56 | 837/2310C/N4/03 |
| DC058 | Service Facility Number | N/A | 837/2310C/REF/G2/02 |
| DC101 | Subscriber Last Name | 12 | 837/2010BA/NM1/ /03 |
| DC102 | Subscriber First Name | 12 | 837/2010BA/NM1/ /04 |
| DC103 | Subscriber Middle Name | 12 | 837/2010BA/NM1/ /05 |
| DC104 | Member Last Name | 20 | 837/2010BA/NM1/ /03, 837/2010CA/NM1/ /03 |
| DC105 | Member First Name | 20 | 837/2010BA/NM1/ /04, 837/2010CA/NM1/ /04 |
| DC106 | Member Middle Name | 20 | 837/2010BA/NM1/ /05, 837/2010CA/NM1/ /05 |
| DC107 | Member Address Line 1 | 20 | 837/2010BA/N3/01, 837/2010CA/N3/01 |
| DC108 | Member Address Line 2 | 20 | 837/2010BA/N3/02, 837/2010CA/N3/02 |
| DC109 | Member Country Code |  | 837/2010BA/N4/04, 837/2010CA/N4/04 |
| DC110 | In-Plan Network Indicator | N/A | N/A |
| DC899 | Record Type | N/A | N/A |