APCD All-Payer Claims Database COUNCIL
A program of NAHDO in partnership with the University of New Hampshire

Institute for Health Policy and Practice

NAHDO

APCD-CDL™

APCD COMMON DATA LAYOUT

Maintained by APCD Council

VERSION 3.0.1 | RELEASED APRIL 1, 2023

APCD-CDL™

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Acknowledgments

Development of the APCD Common Data Layout (APCD-CDL™) was a collaborative effort of the APCD Council Leadership Team, individuals representing states' APCD programs, APCD vendors and data submitters.

Introduction

Overview

All-Payer Claims Databases (APCDs) systematically collect healthcare claim data from the existing transaction systems created to pay healthcare claims. APCDs include data derived from medical, pharmacy, and dental claims, eligibility and provider (physician and facility) files from private and public payers. APCDs are often created by a state mandate and managed by an agency of state government or its designee. APCDs can also be created at a regional or sub-state level, usually by nonprofit organizations such as healthcare-related employer business groups or community coalition organizations. APCDs are used by state agencies, employers, provider, consumers, health plans and other researchers for many purposes including, but not limited to:

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

APCDs are designed with these use cases in mind.

Purpose

The purpose of the APCD Common Data Layout (APCD-CDL™) is to harmonize the data collection efforts across APCDs and reduce the burden of submission. The overall goals of this effort are to improve efficiency, reduce administrative costs, and improve accuracy in data collection.

Technical Specifications

DATA SUBMISSION REQUIREMENTS

File Content

Files in this layout include data elements, data types, field lengths, field description/code assignments, and references to industry standards. The submission of the medical, pharmacy, and dental claim data is based upon the adjudication date within a given reporting period. All files shall be submitted as separate pipe-delimited files with variable field lengths.

The APCD-CDL™ is intentionally silent on establishing data quality thresholds to allow programs flexibility during testing and implementation. Aspects of data quality (e.g., accuracy, completeness, consistency, relevance, timeliness, uniqueness, validity) will vary across state-designated agencies due to differences in law, rule, and technical capability. Data quality also varies by data supplier within a state. For this reason, data quality thresholds are usually established based on submission testing, expectations set with data suppliers, and in consultation with other state agencies collecting these data. Exceptions to data quality thresholds might be negotiated and adjusted over time to improve data quality in compliance with the rules of a state or agency.

Consistent Inter-file Identifier

The files in this layout are intended to be relational. Therefore, it is critical to provide a consistent person identifier across all files for any members, providers, and plans. A health care claims processor and any contracted entity acting on behalf of a carrier shall ensure that member, subscriber, provider, and plan identifiers for the same individuals are unique and consistent across medical claims, pharmacy claims, dental claims and member eligibility files.

CONSIDERATION FOR SPECIFIC DATA FILES

Considerations for adjustment records and financial amounts potentially apply to all claim types:

Adjustment Records

The APCD-CDL™ includes elements that allow post-adjudication claims data to be adjusted, corrected, and replaced. Business rules vary across payers for adjusting, correcting, and replacing claims and assigning claim and version numbers. Given the expected variation, the APCD-CDL™ remains agnostic on a specific method for claim versioning.

Financial Amounts

Financial amount data elements assume the following:

- The sum of all claim lines for a given claim will equal the total dollar amount of the following financial amount data elements: Charge Amount, Withhold Amount, Plan Paid Amount, Co-Pay Amount, Coinsurance Amount, Deductible Amount, Other Insurance Paid Amount, COB/TPL Amount, and Allowed Amount (elements may differ among the medical, pharmacy and dental claims files).
- Mutually exclusive non-charge financial amounts (i.e., withhold, plan paid, co-pay, coinsurance, deductible, other insurance paid, COB/TPL, and allowed).

Member as Subscriber

There is a one-to-one relationship between subscriber and member for Medicare and Medicaid plans, meaning the member is always the subscriber. In all instances where the member is the subscriber, regardless of carrier or plan type, include the subscriber information in the member data element.

FILE TYPES

Header and Trailer Records

Each file submission must contain a header and trailer record. The header record is the first row of each file submitted and the trailer record is the last.

Member Eligibility File (ME)

A member eligibility file is composed of demographic and plan data for each member enrolled for medical, pharmacy, or dental benefits coverage for one or more days during the reporting period. Data suppliers must provide records for all members, regardless of whether a member utilized services during the reporting period. One record, per member, per month, per plan, is required. For example, if a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has two contract numbers for two different coverage types, two-member eligibility records must be submitted. References to the Accredited Standards Committee (ASC) X12N 270/271 implementation guides are provided in the tables below.

Medical Claims File (MC)

A medical claims file is a data file composed of service-level claim and remittance information, including, but not limited to member demographics, provider information, charge/payment/allowed information, clinical diagnosis codes, and procedure codes from all adjudicated claims for each billed service. Data suppliers must report medical service paid claims and encounters data for all applicable/covered members. For the purposes of the descriptions in the tables below, the term “claims” means “claims and encounters”. Many descriptions in the tables below refer to “inpatient” claims; please refer to the National Uniform Billing Committee for the definition of “inpatient”. References to the ASC X12N Post

Adjudicated Claims Data Reporting Guides (Institutional and Professional) are provided in the tables below.

Pharmacy Claims File (PC)

A pharmacy claims file is a data file composed of service-level claim and remittance information including, but not limited to: member demographics, provider information, charge/payment/allowed information, and national drug codes from all adjudicated prescription drug claims. Data suppliers must provide data for all pharmacy claims for prescriptions that were paid for during the reporting period. References to the National Council for Prescription Drug Programs (NCPDP) Uniform Healthcare Payer Data Standard Implementation Guide Version 27 are provided in the tables below.

Dental Claims File (DC)

A dental claims file is a data file composed of service level claim and remittance information including, but not limited to, member demographics, provider information, charge/payment/allowed information, clinical diagnosis codes, and procedure codes from all adjudicated claims for each billed service. Data suppliers must report dental service paid claims and encounters data for all applicable members. References to the ASC X12N Post Adjudicated Claims Data Reporting Guide (Dental) are provided in the tables below.

Provider File (PV)

A provider file is a data file composed of information including but not limited to: provider identifiers, provider names, specialty codes, and practice locations for all providers included in the Member Eligibility, Medical, Pharmacy, and Dental claim files by the data supplier for the reporting period.

A1 - HEADER				
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLHD001	Record Type	char	2	HD.
CDLHD002	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLHD003	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLHD004	Data Submitter Name	varchar	75	Name of data submitter.
CDLHD005	File Type	char	2	ME=Member Eligibility; MC=Medical Claims; PC=Pharmacy Claims; DC=Dental Claims; PV=Provider File.
CDLHD006	Period Beginning Date	date	6	YYYYMM. Beginning of period covered for Eligibility. Beginning of paid/adjudicated period for Claims. Beginning of period for Provider file updates.

A1 - HEADER				
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLHD007	Period Ending Date	date	6	YYYYMM. End of period covered for Eligibility. End of paid/adjudicated period for Claims. End of period for Provider file updates.
CDLHD008	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.
CDLHD009	Comments	varchar	50	Comments.
CDLHD010	APCD-CDL™ Version Number	varchar	8	The version of the APCD-CDL™ used to produce this file (e.g., 3.0.1).

A2 - TRAILER				
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLTR001	Record Type	char	2	TR.
CDLTR002	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.

A2 - TRAILER				
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLTR003	Payer Code	varchar	8	APCD-assigned identifier of insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLTR004	Data Submitter Name	varchar	75	Name of data submitter.
CDLTR005	File Type	char	2	ME=Member Eligibility; MC=Medical Claims; PC=Pharmacy Claims; DC=Dental Claims; PV=Provider File.
CDLTR006	Extraction Date	date	8	YYYYMMDD; Date file was created.
CDLTR007	Control Total of Paid Amount	int	12	Medical (MC) Pharmacy (PC) and Dental (DC) Claims files only. Provide total paid dollars submitted in the file. Control total for each file (CDLMC125, CDLPC037, CDLDC060). Eligibility and provider file blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).
CDLTR008	Record Count	int	10	Total number of records submitted in the file, excluding header and trailer records.

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code used in the Payer Code field.	N/A
CDLME002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLME003	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER)	271/2100A/NM109 where NM108 = XV
CDLME004	Member Insurance/ Product Category code	char	2	See Appendix G-1: Insurance/Product Category for codes. Use the most granular choice available.	Subscriber: 271/2110CA/EB04 Member: 271/2110DA/EB04
CDLME005	Eligibility Year	int	4	The year for which eligibility is reported in this submission file. YYYY.	N/A
CDLME006	Eligibility Month	char	2	The month for which eligibility is reported in this submission file expressed numerical from 01 to 12.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME007	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. ME006 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, then report a value of "IND". If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	Subscriber: 271/2100CA/REF02 where REF01=1L, IG, 6P Member: 271/2100DA/REF02 where REF01=1L, IG, 6P
CDLME008	Coverage Level Code	char	3	Benefit coverage level selected: CHD=Children Only; DEP=Dependents Only; ECH=Subscriber and Children/Dependents; EMP=Subscriber Only; ESP=Subscriber and Spouse/Life Partner; FAM=Family; SPC=Spouse/Life Partner and Children/Dependents; SPO=Spouse/Life Partner Only.	Subscriber: 271/2110CA/EB02 Member: 271/2110DA/EB02
CDLME009	Medicaid AID Category	varchar	10	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME010	Subscriber Social Security Number	char	9	Subscriber's Social Security Number. Do not include dashes. Leave blank if not collected.	271/2100CA/REF02 where REF01 = SY
CDLME011	Plan Specific Contract Number	varchar	80	Plan assigned contract number. If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid eligibility record, provide Medicaid ID.	Subscriber: 271/2100CA/NM109 where NM108=MI
CDLME012	Subscriber Last Name	varchar	60	The subscriber's last name.	271/2100CA/NM103
CDLME013	Subscriber First Name	varchar	35	The subscriber's first name.	271/2100CA/NM104
CDLME014	Subscriber Middle Initial	char	1	The subscriber's middle initial.	271/2100CA/NM105
CDLME015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber use subscriber sequence number.	N/A
CDLME016	Member Social Security Number	char	9	Member's Social Security Number. Do not include dashes. Leave blank if not collected.	271/2100DA/REF02 where REF01=SY

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship Code is maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	Subscriber: 271/2100CA/INS02 Member: 271/2100DA/INS02 where INS01=N
CDLME018	Member Sex	char	1	Sex of the member. M=Male; F=Female; U=UNKNOWN. Member sex represents biological or administrative sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values). If the member is the subscriber, report the subscriber's sex.	Subscriber: 271/2100CA/DMG03 Member: 271/2100DA/DMG03

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME019	Member Date of Birth	date	8	Date of birth of the member. If the member is the subscriber, report the subscriber's date of birth. YYYYMMDD.	Subscriber: 271/2100CA/DMG02 Member: 271/2100DA/DMG02
CDLME020	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	Subscriber: 271/2100CA/NM103 Member: 271/2100DA/NM103
CDLME021	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	Subscriber: 271/2100CA/NM104 Member: 271/2100DA/NM104
CDLME022	Member Middle Initial	char	1	The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.	Subscriber: 271/2100CA/NM105 Member: 271/2100DA/NM105

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME023	Member Street Address	varchar	55	First line of street address of member's residence. If the member is the subscriber, report the street address of the subscriber's residence.	Subscriber: 271/2100CA/N301 Member: 271/2100DA/N301
CDLME024	Member City Name	varchar	30	City location of member's residence. If the member is the subscriber, report the city location of the subscriber's residence.	Subscriber: 271/2100CA/N401 Member: 271/2100DA/N401
CDLME025	Member State or Province	char	2	State or province of member's residence. If the member is the subscriber, report the state or province of the subscriber's residence. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	Subscriber: 271/2100CA/N402 Member: 271/2100DA/N402
CDLME026	Member ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the member's residence. If the member is the subscriber, report the Zip Code of the subscriber's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	Subscriber: 271/2100CA/N403 Member: 271/2100DA/N403

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME027	Member FIPS County Code	char	5	Report the FIPS county code based on the member's residential address. If the member is the subscriber, report the FIPS county code of the subscriber's residence. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. If member lives outside US, leave blank. See Appendix H: External Code Source, United States Census Bureau.	N/A
CDLME028	Member Country Code	char	2	Country of member's residence. If the member is the subscriber, report the country code of the subscriber's residence. Report two-digit code. Code US for United States. See Appendix H: External Code Source, United States Postal Service.	N/A
CDLME029	Race 1	varchar	6	Report the Member-identified race. If the member is the subscriber, report the subscriber's race. The code value "UN" (Unknown/not specified) should be used ONLY when Member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix H: External Code Sources, Centers for Disease Control and Prevention	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME030	Race 2	varchar	6	Report the Member-identified race. If the member is the subscriber, report the subscriber's race. The code value "UN" (Unknown/not specified) should be used ONLY when Member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix H: External Code Sources, Centers for Disease Control and Prevention	N/A
CDLME031	Race 3	varchar	6	Report the Member-identified race. If the member is the subscriber, report the subscriber's race. The code value "UN" (Unknown/not specified) should be used ONLY when Member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix H: External Code Sources, Centers for Disease Control and Prevention	N/A
CDLME032	Hispanic Indicator	char	1	Report the value that defines the element. The code value "U" for unknown, should be used ONLY when the member/subscriber answers unknown or refuses to answer. Report only collected data. If not available leave blank. Y=Member is Hispanic/Latino/Spanish; N=Member is not Hispanic/Latino/Spanish; U=Unknown/not specified.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME033	Ethnicity 1	varchar	6	Report the self-reported ethnicity using the six-character Concept Code that best describes the information obtained from the Member/Subscriber. For example, the Concept Code for an ethnicity value of Costa Rican is “2156-8”, and the Concept Code for an ethnicity value of Hispanic is “2135-2”. The value “UNKNOW” should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data and leave blank if not available. See Appendix H: External Code Sources, Centers for Disease Control and Prevention.	N/A
CDLME034	Ethnicity 2	varchar	6	Report the self-reported ethnicity using the six-character Concept Code that best describes the information obtained from the Member/Subscriber. For example, the Concept Code for an ethnicity value of Costa Rican is “2156-8”, and the Concept Code for an ethnicity value of Hispanic is “2135-2”. The value “UNKNOW” should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data and leave blank if not available. See Appendix H: External Code Sources, Centers for Disease Control and Prevention.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME035	Other Ethnicity	varchar	6	Report the self-reported ethnicity using the six-character Concept Code that best describes the information obtained from the Member/Subscriber. For example, the Concept Code for an ethnicity value of Costa Rican is “2156-8”, and the Concept Code for an ethnicity value of Hispanic is “2135-2”. The value “UNKNOW” should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data and leave blank if not available. See Appendix H: External Code Sources, Centers for Disease Control and Prevention.	N/A
CDLME036	Medical Coverage Under This Plan	char	1	Use this field to indicate whether medical coverage is part of this member’s plan (Note: medical coverage may be bundled with other types of coverage) Medical coverage includes any type of coverage besides prescription drug. Y=Yes; N=No.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME037	Pharmacy Coverage Under This Plan	char	1	Use this field to indicate whether pharmacy coverage is part of this member's plan (Note: pharmacy coverage may include prescription drugs, supplies and DME; and may be bundled with other types of coverage) Y=Yes; N=No.	N/A
CDLME038	Dental Coverage Under This Plan	char	1	Use this field to indicate whether dental coverage is part of this member's plan (Note: dental coverage may be bundled with other types of coverage) Y=Yes; N=No.	N/A
CDLME039	Behavioral Health Coverage Under this Plan	char	1	Use this field to indicate whether behavioral health coverage is part of this member's plan (Note: behavioral health coverage may be bundled with other types of coverage). Valid codes include: Y=Yes; N=No.	N/A
CDLME040	Primary Insurance Indicator	char	1	Use this field to report whether the policy for this eligibility record is the primary insurance for the member. Y=Yes, primary insurance; N=No, this is not the member's primary insurance.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME041	Coverage Type	char	3	This field identifies which entity holds the risk. ASW=Self-funded plans administered by a TPA, where the employer has purchased stop-loss, or group excess insurance coverage; ASO=Self- funded plans administered by a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage; STN=Short-term, non-renewable health insurance (e.g., COBRA); UND=Plans underwritten by the insurer (i.e., fully insured group and individual policies); MEW=Associations/Trusts and Multiple Employer Welfare Arrangements; OTH=Any other plan (e.g., student health plan). States may require prior approval to use OTH.	N/A
CDLME042	Plan State	char	2	State in which the plan is sold/sitused. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	N/A
CDLME043	Market Category Code	varchar	4	Code for identifying market category. See Appendix G-3: Market Category Codes which defines the market category by size and or association to which the policy is directly sold and issued. Report subscribers (not employees).	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME044	Special Coverage	varchar	6	Reserved for specific state coverage. 0=Not applicable; XXXXXX=Specific state coverage.	N/A
CDLME045	Group Name	varchar	60	Name of the group which is covering the member (the name established in the payer's system and not the full legal name). If the member is a group of one, or covered by an individual non-group, Medicaid, or Medicare policy, then report a value of "IND".	N/A
CDLME046	Member PCP ID	varchar	35	Unique code identified for the Primary Care Provider (PCP). If the member is the subscriber, report the subscriber's PCP. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank.	N/A
CDLME047	NPI of Member's PCP	char	10	NPI of the member's Primary Care Provider. If the member is the subscriber, report the NPI of the subscriber's PCP. If not applicable, leave blank.	N/A
CDLME048	PCP Assignment	char	1	1=PCP in CDLME046 was selected by the member; 2=PCP in CDLME046 was attributed by the health plan; 3=PCP is not selected, and no services rendered; 4=PCP is not assigned/unknown.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME049	Member PCP Effective Date	date	8	Primary Care Provider Effective Date with member if CDLME048=1 or 2 (PCP Assignment). If the member is the subscriber, report the subscriber's PCP effective date. Report the date in YYYYMMDD format. If not applicable, leave blank.	N/A
CDLME050	Plan Effective Date	date	8	YYYYMMDD. Effective date of coverage; Date eligibility started for this member under this plan type. The purpose of this data element is to maintain an eligibility span for each member.	N/A
CDLME051	Plan Term Date	date	8	YYYYMMDD. Last continuous day of coverage (date eligibility ended) for this member under this plan. The purpose of this data element is to maintain an eligibility span for each member. For open contracts, leave blank.	N/A
CDLME052	HIOS Plan indicator	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Is the member enrolled in a Health Insurance Oversight System plan? 1=Yes; 2=No; 3=Unknown/not applicable.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME053	HIOS Plan ID	varchar	16	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Required for qualified health plans (QHPs) as defined in the Patient Protection and Affordable Care Act (ACA). If CDLME052 is NOT=1, leave blank. The HIOS Plan ID (Standard Component) includes a five-digit issuer ID, two-character state ID, 3-digit product number, four-digit standard component number and two-digit variant component ID. This field may not be available for all market segments. If not applicable, leave blank.	N/A
CDLME054	Metal Tier	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements: 0=Not a QHP or catastrophic plan; 1=Catastrophic; 2=Bronze; 3=Silver; 4=Gold; 5=Platinum. If not applicable, leave blank.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME055	Medical Home Indicator	int	1	Use this field to report whether the member had a medical home on record for this coverage period. If not stored in payer system, use code '3'. Valid codes include: 1=Yes; 2=No; 3=Unknown/not applicable.	N/A
CDLME056	Payer assigned ID for Medical Home	varchar	35	Unique code identified for the Medical Home (as assigned by the reporting entity). Payer assigned ID for the Medical Home is for the Medical Home to which the member belongs. Payer assigned ID for the Medical Home is the identifier used by the payer for internal identification purposes and does not routinely change. Must correspond to a Payer Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank.	N/A
CDLME057	Enrolled Through a Public Health Insurance Exchange	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Use this field to report whether the policy for this eligibility record was enrolled through a Public Health Insurance Exchange. Valid codes include: 1=Yes; 2=No; 3=Unknown/ not applicable.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME058	Employer Tax ID	char	9	Subscriber's employer EIN or SSN – do not include dashes or provide any punctuation. If coverage not purchased through or enrolled by an employer, leave blank. If not received leave blank.	N/A
CDLME059	Employment Status	char	1	Report the code that defines the employment status of the member/subscriber: A=Active; I=Involuntary Leave; P=Pending; R=Retiree; Z=Unemployed; U=Unknown.	N/A
CDLME060	Employer ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the employer (as reported in CDLME058) When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. If coverage not purchased through or enrolled by an employer, leave blank. ZIP Codes are maintained by the US Postal Service. See Appendix H: External Code Source.	N/A
CDLME061	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME062	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLME063	NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. Leave blank if entity does not have a NAIC Code. See Appendix H: External Code Source; NAIC codes are maintained by the National Association of Insurance Commissioners.	N/A
CDLME064	High Deductible Plan Indicator	char	1	High deductible plan as defined by the IRS at start of plan year. Valid codes include: Y=Yes; N=No. If not applicable, leave blank.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME065	Total Monthly Premium Amount	int	12	For fully-insured premiums, report the monthly fee paid by a subscriber and/or employer for health insurance coverage for a given number of members (e.g. individual, individual plus one, family), prior to any medical loss ratio rebate payments, but inclusive of any fees paid to a third party (e.g., exchange fees, reinsurance). Report the total monthly premium at the Subscriber level only. Do not report on member lines. Report 0 if no premium is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLME066	Actuarial Value	dec	6, 4	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Report value as calculated in the most recent version of the HHS Actuarial Value Calculator. Include decimal point with reported value. Format to be used is 0.0000. For example, an AV of 88.27689% should be reported as 0.8828. Required as of January 1, 2014, for small group and non-group (individual) plans sold inside or outside the Exchange. If not applicable, leave blank. See Appendix H: External Code Source, Centers for Medicaid and Medicare Services.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME067	Grand-fathered Plan Indicator	char	1	Indicates if a plan qualifies as a "Grandfathered" or "Transitional Plan" under the Affordable Care Act (ACA). Please see definition for "grandfathered" and "transitional" in HHS rules 45-CFR-147.140: https://www.federalregister.gov/select-citation/2013/06/03/45-CFR-147. The values of the indicator are as follows: 1=Grandfathered; 2=Non-Grandfathered; 3=Transitional; 4=Not Applicable.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME068	Cost-Sharing Reduction Indicator	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Indicates cost-sharing reduction under the Affordable Care Act (ACA). This is a person- level indicator in which enrollees who qualify for cost-sharing reduction are assigned cost- sharing indicator values of 1-8. Non-Cost-Sharing recipients are assigned a cost-sharing indicator value of zero. Valid codes include: 1=Enrollees in 94% Actuarial Value (AV) Silver Plan Variation; 2=Enrollees in 87% AV Silver Plan Variation; 3=Enrollees in 73% AV Silver Plan Variation; 4=Enrollees in Zero Cost Sharing Plan Variation of Platinum Level QHP (Qualified Health Plan); 5=Enrollee in Zero Cost Sharing Plan Variation of Gold Level QHP; 6=Enrollee in Zero Cost Sharing Plan Variation of Silver Level QHP; 7=Enrollee in Zero Cost Sharing Plan Variation of Bronze Level QHP; 8=Enrollee in Limited Cost Sharing Plan Variation; 0=Non-CSR recipient, and enrollees with unknown CSR.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME069	Administrative Service Fees	int	12	Administrative Service Fees (ASFs): Average monthly fee paid by an employer to cover its self- insured health plan administration, excluding any stop-loss premiums, and divided by the number of members under administration. Administrator services for these fees may vary, including plan design and network access, claims adjudication and administration, and/or population health management. Primary reporting goal will be to monitor self-insured coverage costs over time, using ASFs as one component of a "premium- equivalent." Report 0 if no fee is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Required when CDLME041=ASW or ASO.	N/A

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME070	Tiered Network	char	1	Tiered Network: Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality and/or the cost of care provided. Tiers are not considered separate networks, but rather sub-segments of a payer's HMO or PPO network. A tiered network is different than a plan only splitting benefits by in- network vs. out-of-network; a tiered network will have varying degrees of payments of in-network providers. Report the code that defines the tier network of the member/subscriber's plan: 0=Limited Network; 1=Single Tier-Not tiered; 2=Two Tier; 3=Three Tier; 4=Four Tier; 5=Other.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME071	Member Income Frequency Code	char	1	Report the frequency for the member income as reported at enrollment: 1=Weekly; 2=Bi-Weekly; 3=Semi-Monthly; 4=Monthly; 6=Daily; 7=Annually; 8=Two calendar months; 9=Lump sum separation allowance. If the member is the subscriber, report the subscriber's income frequency.	834/2100A/ICM01
CDLME072	Member Income Monetary Amount	int	12	Member's annual income as reported during enrollment. If the member is the subscriber, report the subscriber's income. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	834/2100A/ICM02
CDLME073	Member Primary Language	char	3	Report the primary language of the member. If the member is the subscriber, report the subscriber's primary language. See Appendix H: External Code Source, ISO 639 Language Codes	834/2100/LUI02

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME074	Un-assigned	char	1	Reserved for future use. Elements will only be added with approval from the APCD-CDL™ Maintenance and Change Committee.	N/A
CDLME075	Member Medicare Beneficiary Identifier	varchar	11	Member's Medicare Beneficiary Identifier. Required only for Medicare Supplemental/Companion.	271/2100CA/NM109 where NM108 = MI
CDLME076	ACO Identifier	varchar	30	APCD agencies will provide guidance as to what values are to be reported in this field	N/A
CDLME077	ACO Name	varchar	60	APCD agencies will provide guidance as to what values are to be reported in this field	N/A
CDLME078	Physician Organization Identifier	varchar	30	For managed care members assigned a PCP, the identifier of the physician group or provider organization or to which the PCP belongs. APCD agencies may provide state-specific guidance on what IDs to use	N/A
CDLME079	Vision Coverage Indicator	char	1	Use this field to indicate whether vision coverage is part of this member's plan. (Note: vision coverage may be bundled with other types of coverage.) Y=Yes; N=No.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME080	Financial Risk Type	int	1	Indicate the type of capitated financial risk contract(s) for a member to the member eligibility file, including the following values: 1=Professional capitation only (no facility capitation); 2=Facility capitation only (no professional capitation); 3=Professional and facility capitation (plan has separate capitation contracts for professional services (with PO) and facility costs (generally with hospital)); 4=Global capitation (single contract with PO for both professional and facility); 5=No capitation, fee-for-service only; 6=Other.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME081	Member Gender Identity	varchar	4	A person's internal sense of being a man, woman, both, or neither. 1=Male; 2=Female; 3=Female-to-Male (FTM)/Transgender Male/Trans Man; 4=Male-to-Female (MTF)/Transgender Female/Trans Woman; 5=Genderqueer, neither exclusively male nor female; 6=Additional gender category or other; 7=Choose not to disclose. If the member is the subscriber, report the subscriber's gender identity.	N/A

B - ELIGIBILITY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N 271 and 834 References**
CDLME082	Member Sexual Orientation	varchar	4	A person's identification of their emotional, romantic, sexual, or affectional attraction to another person. 1=Lesbian, gay, or homosexual; 2=Straight or heterosexual; 3=Bisexual; 4=Something else; 5=Don't know; 6=Choose not to disclose. If the member is the subscriber, report the subscriber's sexual orientation.	N/A
CDLME083	Member Street Address 2	varchar	55	Second line of street address of member's residence. If the member is the subscriber, report the street address of the subscriber's residence.	Subscriber: 271/2100CA/N302 Member: 271/2100DA/N302
CDLMEXXX	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLME899	Record Type	char	2	Value=ME.	N/A

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLMC002).	N/A
CDLMC002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLMC003	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	837/2010AC/NM109 where NM108 = XV
CDLMC004	Member Insurance/ Product Category Code	char	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available.	271/2110DA/EB04

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC005	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLMC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	837/2300/REF02 where REF01=F8
CDLMC006	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	837/2400/LX01
CDLMC007	Version Number	int	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, Cross Reference Claims ID (CDLMC008) is to be utilized.	N/A
CDLMC008	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLMC005). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLMC007) is not used.	N/A

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC009	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLME007 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, then report a value of "IND". If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	837/2320A/SBR03
CDLMC010	Medicaid AID Category	varchar	10	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A
CDLMC011	Subscriber Social Security Number	char	9	Subscriber's Social Security Number. Do not include dashes. Leave blank if not collected.	837/2010BA/REF02 where REF01 = SY

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC012	Plan Specific Contract Number	varchar	80	Plan assigned contract number. Leave blank if Plan Specific Contract Number is the subscriber's Social Security Number. If this is a Medicaid claim, provide Medicaid ID.	Subscriber: 837/2010BA/NM109 where NM108 = MI Member/Patient: 837/2010CA/NM109 where NM108 = MI
CDLMC013	Subscriber Last Name	varchar	60	The subscriber's last name.	837/2010BA/NM103
CDLMC014	Subscriber First Name	varchar	35	The subscriber's first name.	837/2010BA/NM104
CDLMC015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.	N/A
CDLMC016	Member Social Security Number	char	9	Member's Social Security Number. If the member is the subscriber, report the subscriber's SSN. Do not include dashes. Leave blank if not collected.	Subscriber: 837/2010BA/REF102 where REF01 = SY Member/Patient: 837/2010CA/REF102 where REF01 = SY

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, see Accredited Standards Committee.	Subscriber: 837/2000B/SBR02 Member/Patient: 837/2000C/PAT01
CDLMC018	Member Sex	char	1	Sex of the Member. M=Male; F=Female; U=Unknown. Member sex represents biological or administrative sex. If the member is the subscriber, report the subscriber's sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have regarding physical or legal sex (e.g., administrative sex as categorized by X12 values).	Subscriber: 837/2010BA/DMG03 Member/Patient: 837/2010CA/DMG03
CDLMC019	Member Date of Birth	date	8	YYYYMMDD; Date of birth of member. If the member is the subscriber, report the subscriber's date of birth.	Subscriber: 837/2010BA/DMG02 Member/Patient: 837/2010CA/DMG02

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC020	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	Subscriber: 837/2010BA/NM103 Member/Patient: 837/2010CA/NM103
CDLMC021	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	Subscriber: 837/2010BA/NM104 Member/Patient: 837/2010CA/NM104
CDLMC022	Member ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the member's residence. If the member is the subscriber, report the Zip Code of the subscriber's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	Subscriber: 837/2010BA/N403 Member/Patient: 837/2010CA/N403
CDLMC023	Patient Control Number	varchar	20	Patient secondary identification. Patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services.	Subscriber: 837/2010CA/REF02 Member/Patient: 837/2010CA/REF02

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC024	Paid Date	date	8	YYYYMMDD. Paid date of the claim line. Report the date that appears on the: check, and/or remit, and/or explanation of benefits, and corresponds to any and all types of payment in YYYYMMDD Format. If paid/adjudicated date is not available, use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here.	837/2330A/DTP03 where DTP01=573
CDLMC025	Admission Date	date	8	YYYYMMDD. Required for all inpatient claims, this is the date of admission.	837/2300/DTP03 where DTP01=435 (I)
CDLMC026	Admission Hour	char	4	HHMM. (Military time) The hour during which the patient was admitted for inpatient care.	837/2300/DTP03 where DTP01=435 and DTP02=DT (I)
CDLMC027	Admission Type	char	1	Required for all inpatient claims. Valid codes are: 1=Emergency; 2=Urgent; 3=Elective; 4=Newborn; 5=Trauma Center; 9=Information not available. For professional claims, leave blank. Admission Type codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	837/2300/CL101 (I)

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC028	Point of Origin	char	1	A code indicating the point of patient origin for this admission or visit. Required for all institutional claims. Admission Type codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	837/2300/CL102 (I)
CDLMC029	Discharge Date	date	8	YYYYMMDD. Date patient discharged. Required for all inpatient claims.	837/2300/HI01-03 where HI01-02 = 42
CDLMC030	Discharge Hour	char	4	HHMM (Military time). The hour during which the patient was discharged from inpatient care. For professional claims, leave blank.	837/2300/DTP03 where DTP01=096 and DTP02=TM (I)
CDLMC031	Discharge Status	char	2	Required for all institutional claims. Discharge Status codes are maintained by NUBC. For professional claims, leave blank. See Appendix H: External Code Source, National Uniform Billing Committee.	837/2300/CL103 (I)
CDLMC032	Type of Bill – Institutional	char	3	Required for institutional claims. Not to be used for professional claims. As defined by the National Uniform Billing Committee. Do not include the leading zero. Type of Bill codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	837/2300/CLM05-02 & CLM05-03 (I)

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC033	Place of Service – Professional	char	2	Required for professional claims. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix H: External Code Source, Center for Medicaid and Medicare Services.	837/2300/CLM05-01 (P)
CDLMC034	Admitting Diagnosis	varchar	7	The ICD code describing the patient's diagnosis at the time of admission. Required on all inpatient admission claims and encounters. Codes found in ICD-9-CM or ICD -10-CM. Do not code decimal point. See Appendix H: External Code Source, World Health Organization.	837/2300/HI01-02 (I)
CDLMC035	First External Cause Code	varchar	7	The ICD diagnosis codes pertaining to environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. As submitted by provider in the first external cause field- if not submitted by the provider or captured by the carrier leave blank. Codes found in ICD-9-CM or ICD -10-CM. Do not code decimal point. See Appendix H: External Code Source, World Health Organization.	837/2300/HI01-02 where HI01-01=ABJ (ICD- 10)
CDLMC036	ICD Version Indicator	char	1	The purpose of this field is to identify which code set is being utilized. 9=This claim contains ICD-9-CM codes. 0=This claim contains ICD-10-CM codes.	N/A

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC037	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. Cannot include codes V00-Y99. See Appendix H: External Code Source.	837/2300/HI01-02 where HI01-01=ABK (ICD-10)
CDLMC038	Other Diagnosis – 1	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI01-02 where HI01-01=ABF (ICD-10)
CDLMC039	Other Diagnosis – 2	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI02-02 where HI02-01=ABF (ICD-10)
CDLMC040	Other Diagnosis – 3	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI03-02 where HI03-01=ABF (ICD-10)
CDLMC041	Other Diagnosis – 4	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI04-02 where HI04-1=ABF (ICD-10)

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC042	Other Diagnosis – 5	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI05-02 where HI05-01=ABF (ICD-10)
CDLMC043	Other Diagnosis – 6	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI06-02 where HI06-01=ABF (ICD-10)
CDLMC044	Other Diagnosis – 7	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI07-02 where HI07-01=ABF (ICD-10)
CDLMC045	Other Diagnosis – 8	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI08-02 where HI08-1=ABF (ICD-10)
CDLMC046	Other Diagnosis – 9	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI09-02 where HI09-01=ABF (ICD-10)

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC047	Other Diagnosis – 10	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI10-02 where HI10-01=ABF (ICD-10)
CDLMC048	Other Diagnosis – 11	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI11-02 where HI11-01=ABF (ICD-10)
CDLMC049	Other Diagnosis – 12	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI12-02 where HI12-01=ABF (ICD-10)
CDLMC050	Other Diagnosis – 13	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI13-02 where HI13-01=ABF (ICD-10)
CDLMC051	Other Diagnosis – 14	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI14-02 where HI14-01=ABF (ICD-10)

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC052	Other Diagnosis – 15	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI15-02 where HI15-01=ABF (ICD-10)
CDLMC053	Other Diagnosis – 16	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI16-02 where HI16-01=ABF (ICD-10)
CDLMC054	Other Diagnosis – 17	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI17-02 where HI17-01=ABF (ICD-10)
CDLMC055	Other Diagnosis – 18	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI18-02 where HI18-01=ABF (ICD-10)
CDLMC056	Other Diagnosis – 19	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI19-02 where HI19-01=ABF (ICD-10)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC057	Other Diagnosis – 20	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI20-02 where HI20-01 =ABF (ICD-10)
CDLMC058	Other Diagnosis – 21	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI21-02 where HI21-01=ABF (ICD-10)
CDLMC059	Other Diagnosis – 22	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI22-02 where HI22-01=ABF (ICD-10)
CDLMC060	Other Diagnosis – 23	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI23-02 where HI23-01=ABF (ICD-10)
CDLMC061	Other Diagnosis – 24	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI24-02 where HI24-01=ABF (ICD-10)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC062	Present on Admission Code -01	char	1	Present on Admission Indicator Principal Diagnosis For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI01-09
CDLMC063	Present on Admission Code -02	char	1	POA Indicator for Other Diagnosis – 1. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI01-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC064	Present on Admission Code -03	char	1	POA Indicator for Other Diagnosis – 2. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI02-09
CDLMC065	Present on Admission Code -04	char	1	POA Indicator for Other Diagnosis – 3. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI03-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC066	Present on Admission Code -05	char	1	POA Indicator for Other Diagnosis – 4. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI04-09
CDLMC067	Present on Admission Code -06	char	1	POA Indicator for Other Diagnosis – 5. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI05-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC068	Present on Admission Code -07	char	1	POA Indicator for Other Diagnosis – 6. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI06-09
CDLMC069	Present on Admission Code -08	char	1	POA Indicator for Other Diagnosis – 7. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI07-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC070	Present on Admission Code -09	char	1	POA Indicator for Other Diagnosis – 8. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI08-09
CDLMC071	Present on Admission Code -10	char	1	POA Indicator for Other Diagnosis – 9. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI09-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC072	Present on Admission Code -11	char	1	POA Indicator for Other Diagnosis – 10. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI10-09
CDLMC073	Present on Admission Code -12	char	1	POA Indicator for Other Diagnosis – 11. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI11-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC074	Present on Admission Code -13	char	1	POA Indicator for Other Diagnosis – 12 For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI12-09
CDLMC075	Present on Admission Code - 14	char	1	POA Indicator for Other Diagnosis – 13. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI13-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC076	Present on Admission Code - 15	char	1	POA Indicator for Other Diagnosis – 14. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI14-09
CDLMC077	Present on Admission Code - 16	char	1	POA Indicator for Other Diagnosis – 15. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI15-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC078	Present on Admission Code - 17	char	1	POA Indicator for Other Diagnosis – 16. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI16-09
CDLMC079	Present on Admission Code- 18	char	1	POA Indicator for Other Diagnosis – 17. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI17-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC080	Present on Admission Code - 19	char	1	POA Indicator for Other Diagnosis – 18. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI18-09
CDLMC081	Present on Admission Code - 20	char	1	POA Indicator for Other Diagnosis – 19. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI19-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC082	Present on Admission Code - 21	char	1	POA Indicator for Other Diagnosis – 20. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI20-09
CDLMC083	Present on Admission Code - 22	char	1	POA Indicator for Other Diagnosis – 21. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI21-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC084	Present on Admission Code - 23	char	1	POA Indicator for Other Diagnosis – 22. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI22-09
CDLMC085	Present on Admission Code - 24	char	1	POA Indicator for Other Diagnosis – 23. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI23-09

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC086	Present on Admission Code - 25	char	1	POA Indicator for Other Diagnosis – 24. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N=No; U=Unknown; W=Not Applicable.	837/2300/HI24-09
CDLMC087	Revenue Code	char	4	Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements. NUBC Code using leading zeroes, left justified, and four digits. For institutional claims only. Not for professional claims. Revenue codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	837/2400/SV201 (I)
CDLMC088	Procedure Code	varchar	5	Healthcare Common Procedural Coding System (HCPCS). This includes the CPT codes maintained by the American Medical Association. This field should not include modifiers. Modifiers are submitted in different fields. See Appendix H: External Code Source, American Medical Association.	837/2400/SV202-02 where SV202-01=HC (I) and 837/2400 SV101-02 where SV101-01=HC (P)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC089	Procedure Modifier – 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	837/2400/SV202-03 (I); and 837/2400 SV101-03 (P)
CDLMC090	Procedure Modifier – 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	837/2400/SV202-04 (I); and 837/2400 SV101-04 (P)
CDLMC091	Procedure Modifier – 3	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	837/2400/SV202-05 (I); and 837/2400 SV101-05 (P)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC092	Procedure Modifier – 4	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	837/2400/SV202-06 (I); and 837/2400 SV101-06 (P)
CDLMC093	ICD-9 CM/10-PCS Principal Procedure Code	char	7	Primary procedure code for this line of service. Do not code decimal point. For institutional claims only. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI01-02 where 2300 HI01-01= BBR (ICD10PCS) (I)
CDLMC094	ICD-9 CM/10-CM-PCS Other Procedure Code – 1	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI01-02 where HI01-01=BBQ (ICD-10) (I)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC095	ICD-9 CM/10-CM- PCS Other Procedure Code – 2	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI02-02 where HI02-01=BBQ (ICD-10) (I)
CDLMC096	ICD-9 CM/10-CM- PCS Other Procedure Code – 3	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI03-02 where HI03-01=BBQ (ICD-10) (I)
CDLMC097	ICD-9 CM/10-CM- PCS Other Procedure Code – 4	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI04-02 where HI04-01=BBQ (ICD-10) (I)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC098	ICD-9 CM/10-CM- PCS Other Procedure Code – 5	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI05-02 where HI05-01=BBQ (ICD-10) (I)
CDLMC099	ICD-9 CM/10-CM- PCS Other Procedure Code – 6	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI06-02 where HI06-01 =BBQ (ICD-10) (I)
CDLMC100	ICD-9 CM/10-CM- PCS Other Procedure Code – 7	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI07-02 where HI07-01= BBQ (ICD-10) (I)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC101	ICD-9 CM/10-CM- PCS Other Procedure Code – 8	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI08-02 where HI08-01=BBQ (ICD-10) (I)
CDLMC102	ICD-9 CM/10-CM- PCS Other Procedure Code –9	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI09-02 where HI09-01=BBQ (ICD-10) (I)
CDLMC103	ICD-9 CM/10-CM- PCS Other Procedure Code – 10	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI10-02 where HI10-01=BBQ (ICD-10) (I)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC104	ICD-9 CM/10-CM- PCS Other Procedure Code – 11	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI11-02 where HI11-01=BBQ (ICD-10) (I)
CDLMC105	ICD-9 CM/10-CM- PCS Other Procedure Code – 12	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI12-02 where HI12-01=BBQ (ICD-10) (I)
CDLMC106	ICD-9 CM/10-CM- PCS Other Procedure Code – 13	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI13-02 where HI13-01=BBQ (ICD-10) (I)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC107	ICD-9 CM/10-CM- PCS Other Procedure Code – 14	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI14-02 where HI14-01=BBQ (ICD-10) (I)
CDLMC108	ICD-9 CM/10-CM- PCS Other Procedure Code – 15	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI15-02 where HI15-01=BBQ (ICD-10) (I)
CDLMC109	ICD-9 CM/10-CM- PCS Other Procedure Code –16	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI16-02 where HI16-01=BBQ (ICD-10) (I)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC110	ICD-9 CM/10-CM- PCS Other Procedure Code – 17	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI17-02 where HI17-01=BBQ (ICD-10) (I)
CDLMC111	ICD-9 CM/10-CM- PCS Other Procedure Code – 18	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI18-02 where HI18-01=BBQ (ICD-10) (I)
CDLMC112	ICD-9 CM/10-CM- PCS Other Procedure Code – 19	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI19-02 where HI19-01=BBQ (ICD-10) (I)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC113	ICD-9 CM/10-CM- PCS Other Procedure Code – 20	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI20-02 where HI20-01= BBQ (ICD- 10) (I)
CDLMC114	ICD-9 CM/10-CM- PCS Other Procedure Code – 21	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI21-02 where HI21-01=BBQ (ICD- 10) (I)
CDLMC115	ICD-9 CM/10-CM- PCS Other Procedure Code – 22	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI22-02 where HI22-01=BBQ (ICD-10) (I)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC116	ICD-9 CM/10-CM- PCS Other Procedure Code – 23	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI23-02 where HI23-01=BBQ (ICD-10) (I)
CDLMC117	ICD-9 CM/10-CM- PCS Other Procedure Code – 24	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI24-02 where HI24-01=BBQ (ICD-10) (I)
CDLMC118	ICD-9 CM/10-CM- PCS Other Procedure Code – 25	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	837/2300/HI25-02 where HI25-01=BBQ (ICD-10) (I)
CDLMC119	Date of Service – From	date	8	YYYYMMDD. First date of service for this service line. Filled for all claim types. (This date should be within the coverage period on the Eligibility file i.e. between the Plan Effective Date and the Plan Term Date on the Eligibility file all inclusive).	837/2300/DTP03 where DTP02=RD8 (I) and 837/2400/DTP03 where DTP01=472

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC120	Date of Service – Thru	date	8	YYYYMMDD Last date of service for this service line. Filled for all claim types.	837/2300/DTP03 where DTP02=RD8 (I) and 837/2400/DTP03 where DTP01=472
CDLMC121	Service Units/ Quantity	dec	8,3	Numeric value of quantity. Count of service units performed.	837/2400/SV205 (I) and 837/2400/SV104 (P)
CDLMC122	Unit of Measure	varchar	2	Type of units reported in CDLMC121. Example codes: DA=Days; MJ=Minutes; UN=Units. If CDLMC121 is blank (not reported), leave CDLMC122 blank.	837/2400/SV204 (I) and 837/2400/SV103 (P)
CDLMC123	Charge Amount	int	12	The line item charge amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2400/SV203 (I) and 837/2400/SV102 (P)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC124	Withhold Amount	int	12	A claim-based payment that is included in total medical expense. Report the amount paid to the provider for this claim line if the provider qualified/met performance guarantees. Report 0 if there is no withhold amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLMC125	Plan Paid Amount	int	12	This is the service line paid amount. This excludes the patient liability. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/SVD02
CDLMC126	Co-Pay Amount	int	12	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the co-pay amount on the first claim line. Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/CAS03 where CAS02 is 3

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC127	Coinsurance Amount	int	12	The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/CAS03 where CAS02 is 2
CDLMC128	Deductible Amount	int	12	Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/CAS03 where CAS02 is 1
CDLMC129	Other Insurance Paid Amount	int	12	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report “0” if the prior payer paid 0 toward this claim line; or if there is no prior payer. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	N/A

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC130	COB/TPL Amount	int	12	Payer paid amount from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2320/AMT02 where AMT01 = D
CDLMC131	Allowed Amount	int	12	When payment arrangement type in CDLMC132 is equal to 01 for capitated services, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. When payment arrangement type in CDLMC132 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2300/HCP02

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC132	Payment Arrangement Type Indicator	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 04=DRG; 05=Pay for Performance; 06=Global Payment; 07=Other; 08=Bundled Payment.	N/A
CDLMC133	Drug Code	char	11	Report the NDC code only when a medication is paid for as part of a medical claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. If not available, leave blank. See Appendix H: External Code Source, United States Food and Drug Administration.	837/2410/LIN03 where LIN02=N4 (I)
CDLMC134	Rendering Provider ID	varchar	35	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that provided the services on the claims. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	837/2010AA/REF02 where REF01=G2 (I) and 837/2420A/REF02 where REF01=G2 (P) or 837/2310B/REF02 where REF01=G2 (P)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC135	Rendering Provider NPI	char	10	Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES.	837/2010AA/NM109 where NMI08 = XX (I) and 837/2420A/NM109 where NM108 = XX (P) or 837/2310B/NM109 where NM108 = XX (P)
CDLMC136	Rendering Provider Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or "non-person entity". HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1=Person; 2=Non-Person Entity.	837/2010AA/NM102 (I) and 837/2420A/NM102 (P) or 837/2310B/NM102 (P)
CDLMC137	In Plan Network Indicator	char	1	A yes/no indicator that specifies if the provider (not the benefit) is within the health plan network. Valid codes are: N=No; Y=Yes; L=Leased Network.	N/A

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC138	Rendering Provider First Name	varchar	35	Individual first name. If CDLMC136=2, leave blank.	837/2010AA/NM104 (I) and 837/2420A/NM104 (P) or 837/2310B/NM104 (P)
CDLMC139	Rendering Provider Middle Name	varchar	25	Individual middle name or initial. If CDLMC136=2, leave blank.	837/2010AA/NM105 (I) and 837/2420A/NM105 (P) or 837/2310B/NM105 (P)
CDLMC140	Rendering Provider Last Name or Organization Name	varchar	60	Full name of provider organization (“non-person entity”) or last name of individual (“person”) provider. CDLMC136 determines if the Rendering Provider is a “person” or a “non-person entity”.	837/2010AA/NM103 (I) and 837/2420A/NM103 (P) or 837/2310B/NM103 (P)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC141	Rendering Provider Suffix	varchar	10	Suffix of Rendering Provider. Leave blank if provider is a facility or organization. The rendering provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD.	837/2010AA/NM107 (I) and 837/2420A/NM107 (P) or 837/2310B/NM107 (P)
CDLMC142	Rendering Provider Specialty	varchar	10	Standard code that identifies the provider specialty for this line of service. Report the HIPAA-compliant healthcare provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix H: External Code Source, National Uniform Claims Committee.	837/2010AA/PRV03 where PRV02 = PXC (I) and 837/2420A/PRV03 (P) or 837/2310B/PRV03 (P)
CDLMC143	Rendering Provider City Name	varchar	30	City where the rendering provider delivered the service.	837/2010AA/N401 (I) and 837/2420C/N401 (P) or 837/2310C/N401 (P)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC144	Rendering Provider State or Province	char	2	State or Province where the rendering provider delivered the service. Codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	837/2010AA/N402 (I) and 837/2420C/N402 (P) or 837/2310C/N402 (P)
CDLMC145	Rendering Provider ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the address where the rendering provider delivered the service. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	837/2010AA/N403 (I) and 837/2420C/N403 (P) or 837/2310C/N403 (P)
CDLMC146	Rendering Provider Group Practice NPI	char	10	NPI of group practice to which a rendering provider is affiliated if different from CDLMC135.	N/A
CDLMC147	Billing Provider ID	varchar	35	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	837/2010AA/REF02 where REF01=G2

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC148	Billing Provider NPI	char	10	NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	837/2010AA/NM109 where NM108=XX
CDLMC149	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	837/2010AA/NM103
CDLMC150	Billing Provider Tax ID	char	9	Tax ID of the billing provider. Do not code punctuation.	837/2010AA/REF02 where REF01=EI
CDLMC151	Referring Provider ID	varchar	35	Payer assigned provider ID for the referring provider. The Referring Provider is the provider who directed the patient for care to the provider that rendered the services being submitted on the claim form. The Referring Provider Number is the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not available, leave blank.	837/2310F/REF02 where REF01=G2 (I) and 837/2310A/REF02 where REF01=G2 (P) or 837/2420F/REF02 where REF01=G2 (P)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC152	Referring Provider NPI	char	10	NPI of the referring provider. The referring provider is the entity or individual that submitted the referral of the service or procedure. The Referring Provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form. If not available, leave blank.	837/2310F/NM109 where NM108=XX (I) and 837/2310A/NM109 where NM108=XX (P) or 837/2420F/NM109 where NM108=XX (P)
CDLMC153	Attending Provider ID	varchar	35	Payer assigned provider ID for the attending provider. On the institutional claim, the Attending Provider is the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending Provider Number is the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not available, leave blank.	837/2310A/REF02 where REF01=G2 (I)
CDLMC154	Attending Provider NPI	char	10	NPI of the attending provider. On the institutional claim, the Attending Provider is the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending and Rendering provider can be the same individual. If not available, leave blank.	837/2310A/NM109 where NM108=XX (I)

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC155	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved- out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. If not available, leave blank. See Appendix H: External Code Source, National Association of Insurance Commissioners.	N/A
CDLMC156	Type of Claim	int	1	Indicates the type of claim that was submitted. Valid codes are: 1=Professional; 2=Institutional/ Facility; 3=Reimbursement Form (Member).	N/A

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC157	Claim Status	char	2	01=Processed as primary; 02=Processed as secondary; 03=Processed as tertiary; 04=Denied; 19=Processed as primary, forwarded to additional payer(s); 20=Processed as secondary, forwarded to additional payer(s); 21=Processed as tertiary, forwarded to additional payer(s); 22=Reversal of previous payment; 23=Not our claim, forwarded to additional payer(s); 25=Predetermination pricing only – No payment.	835/2100/CLP02
CDLMC158	Denied Claim Line Indicator	int	1	Use this field to indicate whether the payer denied this specific line on this specific claim. Valid codes are: 1=Yes (denied); 2=No (not denied).	N/A

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC159	Claim adjustment reason code	varchar	3	Report the claim adjustment reason code. If CDLMC158=1, report the code that defines the reason for denial of the claim line. If not available, leave blank. Reason codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	837/2430/CAS02
CDLMC160	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment; D=Denial.	N/A
CDLMC161	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A

C - MEDICAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLMC162	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLMC163	Rendering Provider Street Address	varchar	55	First line of street address where the rendering provider delivered the service (street number and street name). Include suite number if applicable.	837/2010AA/N301 (I) and 837/2420C/N301 (P) or 837/2310C/N301 (P)
CDLMC164	Medical Record Number	varchar	35	Medical record number of the member.	837/2300/REF02 when REF01=EA
CDLMCXXX	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLMC899	Record Type	char	2	Value=MC.	N/A

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi- tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLPC002).	N/A
CDLPC002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi- tiered to support different platforms).	879-N2
CDLPC003	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	569-J8
CDLPC004	Member Insurance/ Product Category code	char	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available.	A90

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

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

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC014	Subscriber First Name	varchar	35	The subscriber's first name.	717
CDLPC015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.	303-C3
CDLPC016	Member Social Security Number	char	9	Member's Social Security Number. When the member is the subscriber, use subscriber social security number. Do not include dashes. Leave blank if not collected.	332-CY
CDLPC017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes maintained by ANSI ASC X12. See Appendix H: External Code Source.	247

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC018	Member Sex	char	1	Sex of the Member. 1=Male; 2=Female; 0=Unspecified. Member sex represents biological or administrative sex. If the member is the subscriber, report the subscriber's sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values).	305-C5
CDLPC019	Member Date of Birth	date	8	YYYYMMDD; Date of birth of member. If the member is the subscriber, report the subscriber's date of birth.	304-C4
CDLPC020	Member Last Name	varchar	60	Member last name. If the member is the subscriber, report the subscriber's last name.	716
CDLPC021	Member First Name	varchar	35	Member first name. If the member is the subscriber, report the subscriber's last name.	717

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC022	Member ZIP Code	varchar	9	Report the 5- or 9-digit ZIP Code of the member's residence. If the member is the subscriber, report the Zip Code of the subscriber's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	730-TC
CDLPC023	Date Prescription Filled	date	8	YYYYMMDD. Date the prescription was filled.	401-D1
CDLPC024	Paid Date	date	8	YYYYMMDD. Check Date or Adjudication Date of the claim line. Report the date that appears on the: check, and/or remit, and/or explanation of benefits, and corresponds to all types of payment in YYYYMMDD Format. If paid/adjudicated date is not available, use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here.	216 or 578
CDLPC025	Drug Code	char	11	NDC Code for the drug on the claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. See Appendix H: External Code Source, United States Federal Drug Administration.	407-D7

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC026	New Prescription or Refill	char	2	Provide '00' for new prescriptions; for refills, provide the refill number. 00=New prescription; 01–99=Refill.	254
CDLPC027	Generic Drug Indicator	char	2	Indicates whether the drug itself is generic, not how the payer pays it. Valid codes are: 01=Branded drug; 02=Generic drug.	425-DP
CDLPC028	Dispensed as Written Code	char	1	Use this field to indicate how the drug was dispensed: 0=No Product Selection Indicated (may also have missing values); 1=Substitution Not Allowed by Prescriber; 2=Substitution Allowed - Patient Requested That Brand Product Be Dispensed; 3=Substitution Allowed - Pharmacist Selected Product Dispensed; 4=Substitution Allowed - Generic Drug Not in Stock; 5=Substitution Allowed - Brand Drug Dispensed as Generic; 6=Override; 7=Substitution Not Allowed - Brand Drug Mandated by Law; 8=Substitution Allowed - Generic Drug Not Available in Marketplace; 9=Other.	408-D8

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC029	Compound Drug Indicator	char	1	Use this field to indicate whether the drug is a compound drug or non-compound drug. Valid codes are: N=Non-compound drug; Y=Compound drug; U=Unknown.	406-D6
CDLPC030	Compound Drug Name or Compound Drug Ingredient List	char	128	If CDLPC029=Y, then provide the NDC of the compound drug. If no NDC is identified, include the names of the compound drug ingredients. Use semi-colon (;) delimiter for multiple drugs.	N/A
CDLPC031	Formulary Indicator	char	1	Use this field to report if the prescribed drug was on the carrier's formulary list. Valid codes include: 1=Yes; 2=No; 3=Unknown; 4=Other; 5=Not applicable.	N/A
CDLPC032	Quantity Dispensed	int	10	Quantity dispensed.	442-E7
CDLPC033	Days' Supply	int	3	Estimated number of days the prescription will last.	405-D5

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC034	Drug Unit of Measure	varchar	3	Report the code that defines the unit of measure for the drug dispensed in PC033. Valid codes are: EA=Each; F2=International Units; GM=Grams; ML=Milliliters; MG=Milligrams; MEQ=Milliequivalent; MM=Millimeter; UG=Microgram; UU=Unit; OT=Other.	N/A
CDLPC035	Prescription Number	varchar	20	Report the unique prescription identifier.	254 (fill number calculated)
CDLPC036	Charge Amount	int	10	NCPDP refers to this as Gross Amount Due. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	430-DU
CDLPC037	Plan Paid Amount	int	10	NCPDP refers to this as Net Amount Due. Includes all health plan payments and excludes all member payments. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	281

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC038	Allowed Amount	int	12	When payment arrangement type in CDLPC049 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a prescription. When payment arrangement type in CDLPC049 is equal to 02 for fee for service, report the maximum amount contractually allowed. Report 0 if there is no allowed amount Do not code decimal point or provide any punctuation (e.g. $1,000.25 converted to 100025).	N/A
CDLPC039	Sales Tax Amount	int	12	Report the amount of state sales tax applied to this claim line. Report 0 if there is no state tax amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up / down to whole dollars, code zero cents (00) when applicable.	558-AW
CDLPC040	Ingredient Cost/List Price	int	10	Cost of the drug dispensed. Report 0 if there is no Ingredient Cost/List Price Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	506-F6
CDLPC041	Postage Amount Claimed	int	10	Postage amount associated with the claim. Report 0 if there is no Postage Amount Claimed Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC042	Dispensing Fee	int	10	Dispensing fee associated with the claim Report 0 if there is no Dispensing Fee. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	507-F7
CDLPC043	Co-Pay Amount	int	10	Actual co-payment dollar amount paid for which the individual is responsible. (e.g., If the fixed amount is $25 but the cost to the member is $4 report, 400.) Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	518-FI
CDLPC044	Coinsurance Amount	int	10	The dollar amount of coinsurance for this claim line for which an individual is responsible, not the percentage. Report 0 if no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	572-4U
CDLPC045	Deductible Amount	int	10	The dollar amount for this claim line applied to the deductible. Report 0 if there is no deductible amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	517-FH

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC046	COB/TPL Amount	int	12	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/ TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLPC047	Other Insurance Paid Amount	int	10	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report “0” if the prior payer paid 0 toward this claim line; or if there is no prior payer. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	565-J4
CDLPC048	Member Self-Pay Amount	int	12	Report the amount that the member has paid beyond the other patient obligations (e.g., gap on Medicare Part D, or difference between generic and brand) that are not otherwise listed in the file in CDLPC043, CDLPC044, CDLPC045. Report “0” if there is no member Self-Pay Amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up / down to whole dollars, code zero cents (00) when applicable.	505-F5

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC049	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 07=Other.	N/A
CDLPC050	Prescribing Physician ID	varchar	35	Payer assigned provider ID for the prescribing physician. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	N/A
CDLPC051	Prescribing Physician NPI	char	10	NPI number for prescribing physician.	411-DB
CDLPC052	Prescribing Physician First Name	varchar	25	Prescribing Physician's first name or initial.	A92
CDLPC053	Prescribing Physician Last Name	varchar	60	Prescribing Physician's last name.	716
CDLPC054	Pharmacy NCPDP Number	varchar	7	Unique 7-digit number assigned by the National Council for Prescription Drug Program (NCPDP).	N/A

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC055	Pharmacy ID	varchar	35	Payer assigned pharmacy ID. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	201-B1
CDLPC056	Pharmacy Tax ID Number	char	9	Dispensing pharmacy federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBMs may not have this data).	N/A
CDLPC057	Pharmacy NPI	char	10	NPI of the entity or individual (pharmacy) directly providing the service.	201-B1
CDLPC058	Pharmacy Location Street Address	varchar	55	First line of street address of pharmacy that dispensed the prescription, including street number, name. Include suite number if applicable. Relates to CDLPC059-CDLPC061.	728-SU
CDLPC059	Pharmacy Location State	char	2	State or Province where dispensing pharmacy located. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	729-TA
CDLPC060	Pharmacy ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the Pharmacy. When submitting the 9-digit ZIP Code, do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	730-TC

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC061	Pharmacy Country Code	char	2	Country where dispensing pharmacy located. Report two-digit code. Code US for United States. See Appendix H: External Code Sources, United States Postal Service	A93-1T
CDLPC062	Mail-Order Pharmacy Indicator	int	1	Use this field to report if the pharmacy was a mail-order pharmacy. Valid codes include: 1=Yes, mail order pharmacy; 2=No, not a mail order pharmacy; 3=Unknown; 4=Other; 5=Not applicable.	N/A
CDLPC063	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. See Appendix H: External Code Source, National Association of Insurance Commissioners.	N/A

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC064	In Plan Network Indicator	char	1	Use this field to specify if services from the requested provider were provided within the health plan network. Valid values are: N=No; Y=Yes; L=Leased Network.	N/A
CDLPC065	Record Status Code	char	1	Record status codes maintained by NCPDP is the code identifying type of claim. See Appendix H: External Code Source, NCPDP.	A88
CDLPC066	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment; D=Denial.	N/A
CDLPC067	Reject Code	varchar	3	Report the reason code for the denial. Report the code that defines the reason for denial of the claim line. If not available, leave blank. Reason codes are maintained by NCPDP. See Appendix H: External Code Source, NCPDP.	511-FB

D - PHARMACY					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC068	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLPC069	Carrier Specific Unique Subscriber ID	char	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLPC070	Prescriber Specialty	varchar	10	Report the NUCC healthcare provider taxonomy code. See Appendix H: External Code Source, National Uniform Claim Committee.	296
CDLPC071	Pharmacy City	varchar	30	City or town where dispensing pharmacy located.	728-SU
CDLPCXXX	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLPC899	Record Type	char	2	Value=PC.	N/A

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLDC002).	N/A
CDLDC002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLDC003	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	837/2330A/NM109 where NM108=PI
CDLDC004	Member Insurance/ Product Category code	char	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available.	837/2320/SBR09

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC005	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLDC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	837/2330A/REF02 where REF01=F8
CDLDC006	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	837/2400/LX01
CDLDC007	Version Number	int	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, use Cross Reference Claims ID (CDLDC008).	N/A
CDLDC008	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLDC005) Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLDC007) is not used.	N/A

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC009	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLDC009 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, then report a value of "IND". If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	837/2320A/SBR03
CDLDC010	Medicaid AID Category	varchar	10	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A
CDLDC011	Subscriber Social Security Number	char	9	Subscriber's Social Security Number. Do not include dashes. Leave blank if not collected	837/2010BA/REF02 where REF01=SY
CDLDC012	Plan Specific Contract Number	varchar	80	Plan assigned contract number. If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid claim, provide the Medicaid ID.	837/2010BA/NM109 where NM108=MI
CDLDC013	Subscriber Last Name	varchar	60	The subscriber's last name.	837/2010BA/NM103

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC014	Subscriber First Name	varchar	35	The subscriber's first name.	837/2010BA/NM104
CDLDC015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.	N/A
CDLDC016	Member Social Security Number	char	9	Member's Social Security Number. If the member is the subscriber, report the subscriber's SSN. Do not include dashes. Leave blank if not collected.	Subscriber: 837/2010BA/REF02 where REF01=SY Member/Patient: 837/2010CA/REF02 where REF01=SY
CDLDC017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	Subscriber: 837/2000B/SBR02 Member: 837/2000C/PAT01

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC018	Member Sex	char	1	Sex of the Member. M=Male; F=Female; U=Unknown. Member sex represents biological or administrative sex. If the member is the subscriber, report the subscriber's sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values).	Subscriber: 837/2010BA/DMG03 Member/Patient: 837/2010CA/DMG03
CDLDC019	Member Date of Birth	date	8	YYYYMMDD. Date of birth of member. If the member is the subscriber, report the subscriber's date of birth.	Subscriber: 837/2010BA/DMG02 Member/Patient: 837/2010CA/DMG02

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC020	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	Subscriber: 837/2010BA/NM103 Member/Patient: 837/2010CA/NM103
CDLDC021	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	Subscriber: 837/2010BA/NM104 Member/Patient: 837/2010CA/NM104
CDLDC022	Member ZIP Code	varchar	9	Report the 5- or 9-digit ZIP Code of the member's residence. If the member is the subscriber, report the Zip Code of the subscriber's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	Subscriber: 837/2010BA/N403 Member/Patient: 837/2010CA/N403

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC023	Paid Date	date	8	YYYYMMDD. Paid date of the claim line. Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to all types of payment in YYYYMMDD format. If paid/adjudicated date is not available, use Processed Date. Claims paid in full, partial, or zero paid must have a date reported.	837/2330A/DTP03 where DTP01=57
CDLDC024	Place of Service–Professional	char	2	Required for professional claims. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix H: External Code Source, Center for Medicaid and Medicare Services.	837/2300/CLM05-01 where CLM05-02=B
CDLDC025	ICD 10-CM Diagnosis Code	varchar	7	ICD 10-CM Diagnosis Code when applicable. See Appendix H: External Code Source.	837/2300/HI01-2 where HI01-01=ABF (ICD-10)
CDLDC026	ICD-9/ICD-10 Flag	char	1	The purpose of this field is to identify which code set is being utilized. 9=This claim contains ICD-9- CM codes; 0=This claim contains ICD-10-CM codes.	N/A

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC027	Procedure Code	varchar	5	Common Dental Terminology (CDT) or Current Procedure Terminology (CPT) code for the dental procedure on the claim. CDT codes are maintained by American Dental Association. See Appendix H: External Code Source, American Dental Association. CPT codes are maintained by the American Medical Association. See Appendix H: External Code Source, American Medical Association.	837/2400/SV301-02 where SV301-01=AD
CDLDC028	Oral Cavity 1	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity; 01=maxillary arch; 02=mandibular arch; 10=upper right quadrant; 20=upper left quadrant; 30=lower left quadrant; 40=lower right quadrant.	837/2400/SV304-01

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC029	Oral Cavity 2	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity; 01=maxillary arch; 02=mandibular arch; 10=upper right quadrant; 20=upper left quadrant; 30=lower left quadrant; 40=lower right quadrant.	837/2400/SV304-02

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC030	Oral Cavity 3	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity; 01=maxillary arch; 02=mandibular arch; 10=upper right quadrant; 20=upper left quadrant; 30=lower left quadrant; 40=lower right quadrant.	837/2400/SV304-03

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC031	Oral Cavity 4	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity; 01=maxillary arch; 02=mandibular arch; 10=upper right quadrant; 20=upper left quadrant; 30=lower left quadrant; 40=lower right quadrant.	837/2400/SV304-04

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC032	Oral Cavity 5	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity; 01=maxillary arch; 02=mandibular arch; 10=upper right quadrant; 20=upper left quadrant; 30=lower left quadrant; 40=lower right quadrant.	837/2400/SV304-05
CDLDC033	Tooth Number or Letter (1)	varchar	2	Required when CDLDC027=D2000 thru D2999. Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. If not available, leave blank. Tooth Number codes are maintained by the American Dental Association. See Appendix H: External Code Source, American Dental Association.	837/2400/TOO02

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC034	Tooth – 1 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	837/2400/TOO03-01
CDLDC035	Tooth – 1 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	837/2400/TOO03-02
CDLDC036	Tooth – 1 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	837/2400/TOO03-03
CDLDC037	Tooth – 1 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	837/2400/TOO03-04
CDLDC038	Tooth – 1 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	837/2400/TOO03-05

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC039	Tooth Number or Letter (2)	varchar	2	Report the tooth identifier(s) when CDLDC027 is within the given range if a second tooth is involved in the procedure. Required when CDLDC027=D2000 thru D2999. See Appendix H: External Code Source, American Dental Association.	837/2400/TOO02
CDLDC040	Tooth – 2 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	837/2400/TOO03-01
CDLDC041	Tooth – 2 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	837/2400/TOO03-02
CDLDC042	Tooth – 2 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	837/2400/TOO03-03
CDLDC043	Tooth – 2 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	837/2400/TOO03-04

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC044	Tooth – 2 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	837/2400/TOO03-05
CDLDC045	Tooth Number or Letter (3)	varchar	2	Report the tooth identifier(s) when CDLDC027 is within the given range if a third tooth is involved in the procedure. Required when CDLDC027=D2000 thru D2999. See Appendix H: External Code Source, American Dental Association.	837/2400/TOO02
CDLDC046	Tooth – 3 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	837/2400/TOO03-01
CDLDC047	Tooth – 3 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	837/2400/TOO03-02
CDLDC048	Tooth – 3 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	837/2400/TOO03-03

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC049	Tooth – 3 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	837/2400/TOO03-04
CDLDC050	Tooth – 3 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	837/2400/TOO03-05
CDLDC051	Tooth Number or Letter (4)	varchar	2	Report the tooth identifier(s) when CDLDC027 is within the given range if a fourth tooth is involved in the procedure. Required when CDLDC027=D2000 thru D2999. See Appendix H: External Code Source, American Dental Association.	837/2400/TOO02
CDLDC052	Tooth – 4 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	837/2400/TOO03-01
CDLDC053	Tooth – 4 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	837/2400/TOO03-02

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC054	Tooth – 4 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	837/2400/TOO03-03
CDLDC055	Tooth – 4 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	837/2400/TOO03-04
CDLDC056	Tooth – 4 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	837/2400/TOO03-05
CDLDC057	Date of Service – From	date	8	YYYYMMDD. First date of service for this service line. Filled for all claim types. (This date should be within the coverage period on the Eligibility file i.e. between the Plan Effective Date and the Plan Term Date on the Eligibility file all inclusive).	837/2400/DTP03 where DTP01=472 (service line) or 837/2300/DTP03 where DTP01=434

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Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC058	Date of Service – Thru	date	8	YYYYMMDD Last date of service for this service line. Filled for all claim types.	837/2400/DTP03 where DTP01=472 (service line) or 837/2300/DTP03 where DTP01=434
CDLDC059	Charge Amount	int	12	Amount charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2400/SV302
CDLDC060	Plan Paid Amount	int	12	Service line paid amount. This excludes the patient liability. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/SVD02
CDLDC061	Co-pay Amount	int	12	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the co-pay amount on the first claim line. Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430 CAS03 where CAS02=3 (service line) and 837/2320A/CAS03 where CAS02=3

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC062	Coinsurance Amount	int	12	The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/CAS03 where CAS02=2 (service line) and 837/2320A/CAS03 where CAS02=2 (claim)
CDLDC063	Deductible Amount	int	12	Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	837/2430/CAS03 where CAS02=1 (service line) and 837/2320/CAS03 where CAS02=1 (claim)

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC064	Repriced Allowed Amount	Int	12	When payment arrangement type in CDLDC065 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a particular procedure or service. When payment arrangement type in CDLDC065 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay for a particular procedure or service. Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g. $1,000.25 converted to 100025).	837/2400/HCP02 (service line) and 837/2300/HCP02 (claim)
CDLDC065	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 07=Other.	N/A

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC066	Rendering Provider ID	varchar	35	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that provided the services on the claims. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	837/2420A/REF02 where REF01=G2 (service line) or 837/2310B/REF02 where REF01=G2 (claim)
CDLDC067	Rendering Provider NPI	char	10	Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES.	837/2420A/NM109 where NM108 = XX (service line) or 837/2310B/NM109 where NM108 = XX (claim)
CDLDC068	Rendering Provider Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or “non-person entity”. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a “Person.” Valid codes are: 1=Person; 2=Non- Person Entity.	837/2420A/NM102 or 837/2310B/NM102

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC069	Rendering Provider First Name	varchar	35	Individual first name. If CDLDC068=2, leave blank.	837/2420A/NM104 or 837/2310B/NM104
CDLDC070	Rendering Provider Middle Name	varchar	25	Individual middle name or initial. If CDLDC068=2, leave blank.	837/2420A/NM105 or 837/2310B/NM105
CDLDC071	Rendering Provider Last Name or Organization Name	varchar	60	Full name of provider organization (“non-person entity”) or last name of individual (“person”) provider. CDLDC068 determines if the rendering provider is a “person” or a “non- person entity”.	837/2420A/NM103 or 837/2310B/NM103
CDLDC072	Rendering Provider Suffix	varchar	10	Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III).	837/2420A/NM107 or 837/2310B/NM107
CDLDC073	Rendering Provider Specialty	varchar	10	Standard code that identifies the provider specialty for this line of service. Report the HIPAA-compliant healthcare provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix H: External Code Source, National Uniform Claims Committee.	837/2420A/PRV03 or 837/2310B/PRV03

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC074	Rendering Provider City Name	varchar	30	City name of provider or practice location.	837/2420C/N401 or 837/2310C/N401
CDLDC075	Rendering Provider State or Province	char	2	State of provider or practice location. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	837/2420C/N402 or 837/2310C/N402
CDLDC076	Rendering Provider ZIP Code	varchar	9	Report the 5 or 9-digit ZIP Code of the Rendering Provider. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	837/2420C/N403 or 837/2310C/N403
CDLDC077	Rendering Provider Group Practice NPI	varchar	10	NPI of rendering provider group practice to which a practitioner is affiliated if different from CDLDC067.	N/A

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC078	Billing Provider ID	varchar	35	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	837/2010AA/REF02 where REF01=G2
CDLDC079	Billing Provider NPI	char	10	NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	837/2010AA/NM109 where NM108=XX
CDLDC080	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	837/2010AA/NM103
CDLDC081	Billing Provider Tax ID	varchar	10	Tax ID of the billing provider. Do not code punctuation.	N/A

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC082	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved- out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. If not available, leave blank. See Appendix H: External Code Source, National Association of Insurance Commissioners.	N/A
CDLDC083	Claim Status	char	2	01=Processed as primary; 02=Processed as secondary; 03=Processed as tertiary; 04=Denied; 19=Processed as primary, forwarded to additional payer(s); 20=Processed as secondary, forwarded to additional payer(s); 21=Processed as tertiary, forwarded to additional payer(s); 22=Reversal of previous payment; 23=Not our claim, forwarded to additional payer(s); 25=Predetermination pricing only – No payment.	835/2100/CLP02

E - DENTAL					
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12N PACDR and 835 References**
CDLDC084	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment; D=Denial.	N/A
CDLDC085	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLDC086	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLDCXXX	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLDC899	Record Type	char	2	Value=DC	N/A

F - PROVIDER				
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLPV002).
CDLPV002	Payer Code	varchar	8	APCD-assigned identifier of insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLPV003	Plan ID	varchar	30	CMS National Plan ID. The national plan ID is a code assigned by CMS. (PLACEHOLDER).
CDLPV004	Payer Assigned Provider ID	varchar	35	Unique code identified for the provider as assigned by the reporting entity. For every provider included in the Eligibility, Medical, Pharmacy and Dental claims the payer assigned provider IDs shall be included.
CDLPV005	Provider Tax ID	char	9	Tax ID of the provider. Do not code punctuation.

F - PROVIDER				
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV006	Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1=Person; 2=Non-Person Entity.
CDLPV007	Provider NPI	char	10	NPI for provider as enumerated in the Center for Medicaid and Medicare Services NPPES.
CDLPV008	Provider DEA Number	varchar	12	Provider Drug Enforcement Agency number. For all prescribing providers (CDLPC050) that have a DEA number.
CDLPV009	Provider State License Number	varchar	15	Prefix with two-character state of licensure with no punctuation. Example: COLL12345. Do not leave a blank space in between state and license number.
CDLPV010	Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.
CDLPV011	Provider Middle Name or Initial	varchar	25	Individual middle name or initial. If provider is a facility or organization, leave blank.
CDLPV012	Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider.

F - PROVIDER				
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV013	Provider Suffix	varchar	10	Suffix to individual name. If provider is a facility or organization, leave blank. The provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD.
CDLPV014	Provider Office Street Address	varchar	55	First line of the street address for the physical location where the provider delivers healthcare services (street number and street name). Include suite number if applicable. Multiple addresses will require multiple provider records.
CDLPV015	Provider Office City	varchar	30	The city of the physical address where the provider delivers healthcare services. Multiple addresses will require multiple provider records.
CDLPV016	Provider Office State	char	2	The state of the physical address where the provider delivers healthcare services. Use postal service standard 2 letter abbreviations. Multiple addresses will require multiple provider records. See Appendix H: External Code Source, United States Postal Service.
CDLPV017	Provider Office ZIP Code	varchar	9	Report the 5- or 9-digit ZIP Code of the Rendering Provider. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Multiple addresses will require multiple provider records. ZIP Codes are maintained by the US Postal Service. See Appendix H: External Code Source.

F - PROVIDER				
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV018	Provider FIPS County Code	char	5	Report the FIPS county code based on the provider's address. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. If member lives outside US, leave blank. See Appendix H: External Code Source, United States Census Bureau.
CDLPV019	Provider Country Code	char	2	Country of provider's practice location. Report two-digit code. Code US for United States. See Appendix H: External Code Source, United States Postal Service.
CDLPV020	Provider Phone	char	10	Phone number of Provider.
CDLPV021	Provider Specialty	varchar	10	Report the NUCC healthcare provider taxonomy code. See Appendix H: External Code Source, National Uniform Claim Committee.
CDLPV022	Atypical Provider Taxonomy Code	varchar	10	Non-medical or atypical providers not defined as covered entities by CMS. Non-medical providers who supply non-healthcare services, such as non-emergency transportation, will continue to submit claims and other transactions using their current provider ID and taxonomy. Use Code set for Atypical Provider Taxonomy Codes (maintained by NUCC). If not applicable, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.

F - PROVIDER				
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV023	Provider Medicare Provider ID	varchar	30	Provider ID as assigned by Medicare If not available, leave blank.
CDLPV024	Provider Medicaid Provider ID	varchar	30	Provider ID as assigned by Medicaid. If not available, leave blank.
CDLPV025	Provider Specialty 2	varchar	10	Report additional NUCC healthcare provider taxonomy code for second specialty. In addition to the taxonomy code listed in CDLPV021. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.
CDLPV026	Provider Specialty 3	varchar	10	Report third NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.
CDLPV027	Provider Specialty 4	varchar	10	Report fourth NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.
CDLPV028	Provider Specialty-5	varchar	10	Report fifth NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.
CDLPVXXX	Un-assigned			Reserved for future use. Elements will only be added with review from states and payers.

F - PROVIDER				
Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV899	Record Type	char	2	Value=PV.

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-Fault Insurance including Insurance in which Auto Is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
17	Dental
18	Vision
19	Prescription Drugs (Commercial Coverage)
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Is Primary
AP	Auto Insurance Policy

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
C1	Other Commercial (Not Specified Elsewhere)
CO	Consolidated Omnibus Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
E	Medicare – Point of Service (POS)
EP	Exclusive Provider Organization
FH	Federal Employees Health Benefits Program (HMO)
FP	Federal Employees Health Benefits Program (PPO)
FF	Family or Friends
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A (not to be used for commercial plans)
MB	Medicare Part B (not to be used for commercial plans)
MC	Medicaid
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B
MO	Medicare Advantage PPO
MP	Medicare Primary (not to be used for commercial plans)
MT	Medicaid CHIP

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
OT	Other
PE	Property Insurance – Personal
PL	Personal
PP	Personal Payment (Cash – No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance – Real
SP	Supplemental Policy
S1	Medicare Special Needs Plan – Chronic Condition
S2	Medicare Special Needs Plan - Institutionalized
S3	Medicare Special Needs Plan – Dual Eligible
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
TR	Tricare

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
U	Multiple Options Health Plan
VA	Veterans Administration Plan
WC	Workers' Compensation
WU	Wrap Up Policy
11	Other Non-Federal Programs
DM	Dental Maintenance Organization
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	CHAMPUS
CI	Commercial Insurance Company
LB	Liability
LM	Liability Medical
OF	Other Federal Program
TV	Title V

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
SL	Standalone limited (for example, vision only, hearing only)
ZZ	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)

APPENDIX G2 - MARKET CATEGORY CODES	
Code	**Description**
IND	Individuals (non-group)
FCH	Individuals on a franchise basis
GCV	Individuals as group conversion Policies
GS1	Employers having exactly 1 employee
GS2	Employers having 2 thru 9 employees
GS3	Employers having 10 thru 25 employees
GS4	Employers having 26 thru 50 employees
GLG1	Employers having 51 thru 100 employees
GLG2	Employers having 101 thru 250 employees

APPENDIX G2 - MARKET CATEGORY CODES	
Code	**Description**
GLG3	Employers having 251 thru 500 employees
GLG4	Employers having more than 500 employees
GSA	Small employers through a qualified association trust
OTH	Other types of entities. Insurers using this market code shall obtain prior approval.

APPENDIX H - EXTERNAL CODE SOURCES

American Dental Association
Current Dental Terminology (CDT) Codes
SOURCE: Current Dental Terminology (CDT) Manual
AVAILABLE FROM:
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678
ABSTRACT: The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

APPENDIX H - EXTERNAL CODE SOURCES

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

Accredited Standards Committee (ASC)
ASC X12 Directories
SOURCE: PACDR Implementation Guides, ASC X12 005010 Standard
AVAILABLE FROM:
Data Interchange Standards Association, Inc. (DISA)
7600 Leesburg Pike Ste 430
Falls Church, VA 22043
http://store.x12.org/store
Washington Publishing Company http://www.wpc-edi.com/reference/
ABSTRACT: The PACDR Implementation Guides contain the descriptions of data elements used to construct X12 segments. The PACDR Guides also contain code lists associated with these data elements.

APPENDIX H - EXTERNAL CODE SOURCES

Centers for Disease Control and Prevention
SOURCE: Race and Ethnicity Code Set
AVAILABLE FROM:
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329-4027
FILE: 2022_RaceAndEthnicityFinal_TablesforPub_Final.xlsx - Race and Ethnicity Download File (Full Code System, relationships, and Hierarchy codes) found in "CDC Race Category and Ethnicity Group" at https://phinvads.cdc.gov/vads/SearchVocab.action.
ABSTRACT: The race and ethnicity code set is used for coding the race and ethnicity of the member.

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

APPENDIX H - EXTERNAL CODE SOURCES

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

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

APPENDIX H - EXTERNAL CODE SOURCES

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

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

APPENDIX H - EXTERNAL CODE SOURCES

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

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

APPENDIX H - EXTERNAL CODE SOURCES

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

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

APPENDIX H - EXTERNAL CODE SOURCES

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

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

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

APPENDIX H - EXTERNAL CODE SOURCES

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

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

APPENDIX H - EXTERNAL CODE SOURCES

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

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

APPENDIX H - EXTERNAL CODE SOURCES

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