COL	FIELD	LENGTH	NOTES
1	PATIENT ID **(patient_id)**	11	Use First 10 Characters only for SEER cases.
	SEER Cases (Patient ID)		
1	Registry	2	02 = Connecticut 20 = Detroit 21 = Hawaii 22 = Iowa 23 = New Mexico 25 = Seattle 26 = Utah 42 = Kentucky 43 = Louisiana 44 = New Jersey 87 = Georgia 88 = California
3	Case Number	8	Encrypted SEER Case Number
11	Filler	1	Blank Space
	Non Cancer Patients (Patient ID)		
1	HIC **(hicbic)**	11	Encrypted ID for Non Cancer Patients
12	NCH CLAIM TYPE CODE (7) **(clm_type)**	2	The code used to identify the type of Claim record being processed in NCH. 10 = HHA claim 20 = Non swing bed SNF claim 30 = Swing bed SNF claim 40 = Outpatient claim 41 = Outpatient 'Full-Encounter' claim (available in NMUD) 42 = Outpatient 'Abbreviated – Encounter' claim (available in NMUD) 50 = Hospice claim 60 = Inpatient claim 61 = Inpatient 'Full-Encounter' claim 62 = Medicare Advantage IME/GME claims 63 = Medicare Advantage (no-pay) claims 64 = Medicare Advantage (paid as FFS) claims 71 = RIC O local carrier non-DMEPOS claim 72 = RIC O local carrier DMEPOS claim 73 = Physician 'Full-Encounter' claim (Available in NMUD) 81 = RIC M DMERC non-DMEPOS claim 82 = RIC M DMERC DMEPOS claim

Note: The number in parenthesis corresponds to the number of the variable on the CMS Version K file documentation.

COL	FIELD	LENGTH	NOTES
14	BENEFICIARY IDENTIFICATION CODE (12) **(bic)**	2	Relationship between individual and a primary Social Security Administration Beneficiary. (Refer to appendix table BIC)
16	BENEFICIARY RESIDENCE SSA STANDARD STATE CODE (14) **(state_cd)**	2	State of Beneficiary's residence, SSA Standard Code. (Refer to appendix table STATE_CD)
18	CLAIM FROM DATE (15) **(from_dtm, from_dtd, from_dty)**	8	For Institutional or CWFB Claim, first day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
26	CLAIM THROUGH DATE (16) **(thru_dtm, thru_dtd, thru_dty)**	8	Last day of Provider's or Physician/Supplier's Billing statement. MMDDYYYY
34	CLAIM QUERY CODE (22) **(query_cd)**	1	Payment type of claim being processed. 0 = Credit adjustment 1 = Interim bill 2 = Home Health Agency benefits exhausted (obsolete 7/98) 3 = Final bill 4 = Discharge notice (obsolete 7/98) 5 = Debit adjustment
35	PROVIDER NUMBER (23) **(provider)**	6	ID of Medicare Provider certified to provide services to the Beneficiary. ***Encrypted Data. Special Permission required to receive unencrypted data.** For more information: **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R82SOMA.pdf**
59	CLAIM TOTAL SEGMENT COUNT (26) **(sgmt_cnt)**	2	Total number of segments for each claim. (corresponds to total number of original var-length records for each claim. Max = 10)
61	CLAIM SEGMENT NUMBER (27) **(sgmt_num)**	2	Number of each segment. (corresponds to the original var-length record for this claim. Values: 1 to 10)
63	CLAIM TOTAL LINE COUNT (28) **(linecnt)**	3	The total number of Revenue Center lines associated with the claim.

Note: The number in parenthesis corresponds to the number of the variable on the CMS Version K file documentation.

COL	FIELD	LENGTH	NOTES
66	CLAIM SEGMENT LINE COUNT (29) **(sgmtline)**	2	The count used to identify the number of lines on a record/segment.
68	CLAIM FACILITY TYPE CODE (34) **(fac_type)**	1	Facility that provided care. (Refer to appendix table FAC_TYPE)
69	CLAIM SERVICE CLASSIFICATION TYPE CODE (35) **(typesrvc)**	1	Classification of type of service provided to the Beneficiary. (Refer to appendix table TYPESRVC).
70	CLAIM FREQUENCY CODE (36) **(freq_cd)**	1	Sequence of claim in the Beneficiary's current episode of care associated with a given facility. (Refer to appendix table FREQ_CD).
71	BENEFICIARY RESIDENCE SSA STANDARD COUNTY CODE (42) **(cnty_cd)**	3	County of Beneficiary's residence, SSA Standard Code.
74	FI NUMBER (46) **(fi_num)**	5	Assigned by CMS to an Intermediary or Carrier authorized to process claims from Providers or Physician/Suppliers. (Refer to appendix table FI_NUM for Outpatient, HHA, Hospice)
79	BENEFICIARY MAILING CONTACT ZIP CODE (49) **(bene_zip)**	9	Beneficiary's mailing address zip code. ***Encrypted Data. Special Permission required to receive unencrypted data.**
88	CWF BENEFICIARY MEDICARE STATUS CODE (53) **(ms_cd)**	2	Medicare entitlement reason 10 = Aged without ESRD 11 = Aged with ESRD 20 = Disabled without ESRD 21 = Disabled with ESRD 31 = ESRD only
90	CLAIM MEDICARE NON PAYMENT REASON CODE (62) **(nopay_cd)**	2	The reason that no Medicare payment is made for services on an institutional claim. (Refer to appendix table NOPAY_CD).

Note: The number in parenthesis corresponds to the number of the variable on the CMS Version K file documentation.

COL	FIELD	LENGTH	NOTES
92	CLAIM PAYMENT AMOUNT (64) **(pmt_amt)**	15.2	Made to Provider and/or Beneficiary from trust fund (after deductible and coinsurance amounts) for services covered by Institutional claim (does not include pass-through per diem or organ acquisition), or for Physician/Supplier claim. Does not include automatic adjustments. NOTE: If more than one record from the same claim (sorted by Patient ID, Claim ID and Rec_count) is selected, be sure to keep the claim payment amount from the first record only.
107	NCH PRIMARY PAYER CLAIM PAID AMOUNT (65) **(prpayamt)**	15.2	Made on behalf of Beneficiary by a primary payer other than Medicare. Provider is applying to covered Medicare charges on Institutional or CWFB claim.
122	NCH PRIMARY PAYER CODE (66) **(prpay_cd)**	1	Federal non-Medicaid program or other source with primary responsibility for payment of Beneficiary's medical bills. (Refer to appendix table PRPAY_CD)
123	FI CLAIM ACTION CODE (68) **(actioncd)**	1	Action requested by Intermediary to be taken on an Institutional claim. (Refer to appendix table ACTIONCD).
125	NCH PROVIDER STATE CODE (70) **(prstate)**	2	SSA state code where provider facility is located. (Refer to appendix table STATE_CD).
126	ORGANIZATION NPI NUMBER (71) **(orgnpinm)**	10	The NPI assigned to the institutional provider. The NPI may not be available prior to 7/1/2007. **Encrypted Data. * Special permission required to receive unencrypted data.**
136	CLAIM ATTENDING PHYSICIAN UPIN NUMBER (73) **(at_upin)**	6	Institutional claim's state license number or other identifier (like UPIN, required since 1/92) of Physician expected to certify medical necessity of services rendered and/or has primary responsibility for Beneficiary's medical care and treatment. ***Encrypted Data.**
142	CLAIM ATTENDING PHYSICIAN NPI NUMBER (74) **(at_npi)**	10	The NPI assigned to the attending physician. The NPI may not be available prior to 7/1/2007. ***Encrypted Data.**

Note: The number in parenthesis corresponds to the number of the variable on the CMS Version K file documentation.

COL	FIELD	LENGTH	NOTES
152	CLAIM OPERATING PHYSICIAN UPIN NUMBER (79) **(op_upin)**	6	The unique physician ID number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure. ***Encrypted Data.**
159	CLAIM OPERATING PHYSICIAN NPI NUMBER (80) **(op_npi)**	10	The NPI assigned to the operating physician. The NPI may not be available prior to 7/1/2007. ***Encrypted Data.**
168	CLAIM OTHER PHYSICIAN UPIN NUMBER (85) **(ot_upin)**	6	On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim. ***Encrypted Data.**
174	CLAIM OTHER PHYSICIAN NPI NUMBER (86) **(ot_npi)**	10	The NPI assigned to the other physician. The NPI may not be available prior to 7/1/2007. ***Encrypted Data.**
184	PATIENT DISCHARGE STATUS CODE (98) **(stus_cd)**	2	Status of Beneficiary as of Service Through Date on a claim. (Refer to appendix table STUS_CD).
186	CLAIM PPS INDICATOR CODE (102) **(pps_ind)**	1	The code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee. (Refer to appendix table PPS_IND)
187	CLAIM TOTAL CHARGE AMOUNT (103) **(tot_chrg)**	15.2	Total charges for all services included on the institutional claim.
202	CLAIM SERVICE FACILITY ZIP CODE (108) **(srvcfac)**	9	The zip code used to identify the location of the facility where the service was performed. ***Encrypted Data. Special Permission required to receive unencrypted data.** Note: This variable is only available in 2010+.
211	HOSPICE CLAIM DIAGNOSIS CODE COUNT (144) **(hsdgncnt)**	2	The count of the number of diagnosis codes (both principal and secondary) reported on a Hospice claim. The purpose of this count is to indicate how many claim diagnosis trailers are present.
213	HOSPICE REVENUE CENTER CODE COUNT (151) **(hsrevcnt)**	2	The count of the number of revenue codes reported on an HHA claim. The purpose of the count is to indicate how many revenue center trailers are present.

Note: The number in parenthesis corresponds to the number of the variable on the CMS Version K file documentation.

COL	FIELD	LENGTH	NOTES
215	NCH PATIENT STATUS INDICATOR CODE (154) **(ptntstus)**	1	Effective with Version H, the code on an inpatient/SNF and Hospice claim, indicating whether the beneficiary was discharged, died or still a patient (used for internal CWFMQA editing purposes.) A = Discharged B = Died C = Still a patient
216	CLAIM HOSPICE START DATE (155) **(hspcstrtm, hspcstrtd, hspcstrty)**	8	On an institutional claim, the date the beneficiary was admitted to the hospice. MMDDYYYY
224	NCH BENEFICIARY MEDICARE BENEFITS EXHAUSTED DATE (156) **(exhst_dtm, exhst_dtd, exhst_dty)**	8	The last date for which the beneficiary has Medicare coverage. This is completed only where benefits were exhausted before the date of discharge and during the billing period covered by this institutional claim. MMDDYYYY
232	NCH BENEFICIARY DISCHARGE DATE (157) **(dschgdtm, dschrgdtd, dschrgdty)**	8	The date the beneficiary was discharged from the facility or died (used for internal CWFMQA editing purposes.) MMDDYYYY
240	CLAIM UTILIZATION DAY COUNT (158) **(util_day)**	3	On an institutional claim, the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days and lifetime reserve days.
243	BENEFICIARY HOSPICE PERIOD COUNT (159) **(hospcprd)**	1	The count of the number of hospice period trailers present for the beneficiary's record. Prior to BBA a beneficiary was entitled to a maximum of 4 hospice benefit periods that may be elected in lieu of standard Part A hospital benefits. The BBA changed the hospice benefit to the following: 2 initial 90 day periods followed by an unlimited number of 60 day periods (eff. 8/5/97).
244	Claim Service Location NPI Number (171) **(srvcnpi)**	10	The NPI assigned to the claims service center. The NPI may not be available prior to 1/2013. ***Encrypted Data**
254	CLAIM DIAGNOSIS VERSION CODE (193) **(dvrsncd1-dvrsncd25)**	25*1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10

Note: The number in parenthesis corresponds to the number of the variable on the CMS Version K file documentation.

COL	FIELD	LENGTH	NOTES
279	CLAIM DIAGNOSIS CODE (194) **(dgns_cd1-dgns_cd25)**	25*7	ICD-CM codes of any coexisting conditions shown in medical record as affecting services provided. Up to 25 codes may be listed, each with 7 digits.
454	CLAIM RELATED CONDITION CODE (206) **(rlt_cond1-2)**	2*2	The code that indicates a condition relating to an institutional claim that may affect payer processing. (Refer to appendix table RLT_COND)
458	NCH OCCURRENCE TRAILER INDICATOR CODE (208) **(ocrncind1-ocrncind2)**	2*1	The code indicating the presence of an occurrence code trailer. O = Occurrence code trailer present
460	CLAIM RELATED OCCURRENCE CODE (209) **(ocrnc_cd1- ocrnc_cd2)**	2*2	The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date. (Refer to appendix table OCRNC_CD)
464	CLAIM RELATED OCCURRENCE DATE 1 (210) **(ocrncdtm1, ocrncdtd1, ocrncdty1)**	8	The date associated with the first significant event related to an institutional claim that may affect payer processing. MMDDYYYY
472	CLAIM RELATED OCCURRENCE DATE 2 (210) **(ocrncdtm2, ocrncdtd2, ocrncdty2)**	8	The date associated with the second significant event related to an institutional claim that may affect payer processing. MMDDYYYY
480	REVENUE CENTER CODE (222) **(rev_cntr)**	4	Cost center (division or unit within a hospital) for which a separate charge is billed (type of accommodation or ancillary). Assigned by provider. (Refer to appendix table REV_CNTR)
484	REVENUE CENTER DATE (223) **(rev_dtm, rev_dtd, rev_dty)**	8	The date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with the “from date” greater than 3/31/98. With the implementation of outpatient PPS, hospitals with be required to enter line item dates of service for all outpatient services which require a HCPCS. MMDDYYYY

Note: The number in parenthesis corresponds to the number of the variable on the CMS Version K file documentation.

COL	FIELD	LENGTH	NOTES
492	REVENUE CENTER 1ST ANSI CODE (224) **(revansi1)**	5	The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment). (Refer to appendix table REVANSI1)
497	REVENUE CENTER HEALTHCARE COMMON PROCEDURE CODING SYSTEM (229) **(hcpcs_cd)**	5	Health Care Financing Administration Common Procedure Coding System (HCPCS) code. Procedures, supplies, products or services provided to Medicare Beneficiaries. (Refer to appendix table HCPCS_CD)
502	REVENUE CENTER HCPCS INITIAL MODIFIER CODE (230) **(mdfr_cd1)**	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information file)
504	REVENUE CENTER HCPCS SECOND MODIFIER CODE (231) **(mdfr_cd2)**	2	Second modifier to the procedure code to enable a more specific procedure ID. (Carrier Information file)
506	REVENUE CENTER PRICING INDICATOR CODE (238) **(pricing)**	2	The code used to identify if there was a deviation from the standard method of calculating payment amount. (Refer to appendix table PRICING)
508	REVENUE CENTER IDE, NDC, UPC NUMBER (240) **(idendc)**	24	Revenue Center IDE, NDC, UPC number
532	REVENUE CENTER NDC QUANTITY QUALIFIER CODE (241) **(qtyqlfr)**	2	The code used to indicate the unit of measurement for the drug that was administered. (Refer to appendix table QTYQLFR)
534	REVENUE CENTER NDC QUANTITY (242) **(ndcqty)**	12.3	The quantity dispensed for the drug reflected on the revenue center line item.
546	REVENUE CENTER UNIT COUNT (243) **(rev_unit)**	8	A quantitative measure (unit) of services provided to a beneficiary associated with accommodation and ancillary revenue centers described on an institutional claim.
554	REVENUE CENTER RATE AMOUNT (244) **(rev_rate)**	15.2	Charges relating to unit cost associated with the revenue center code.
569	REVENUE CENTER 1ST MEDICARE SECONDARY PAYER PAID AMOUNT (249) **(rev_msp1)**	15.2	The amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary).

Note: The number in parenthesis corresponds to the number of the variable on the CMS Version K file documentation.

COL	FIELD	LENGTH	NOTES
584	REVENUE CENTER 2ND MEDICARE SECONDARY PAYER PAID AMOUNT (250) **(rev_msp2)**	15.2	The amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).
599	REVENUE CENTER PROVIDER PAYMENT AMOUNT (251) **(rprvdpmt)**	15.2	The amount paid to the provider for the services reported on the line item.
614	REVENUE CENTER PAYMENT AMOUNT (254) **(revpmt)**	15.2	Medicare payment amount for the specific revenue center.
629	REVENUE CENTER TOTAL CHARGE AMOUNT (255) **(rev_chrg)**	15.2	Total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.
644	REVENUE CENTER NON-COVERED CHARGE AMOUNT (256) **(rev_ncvr)**	15.2	The charge amount related to a revenue center code for services that are not covered by Medicare.
659	REVENUE CENTER DEDUCTIBLE COINSURANCE CODE (257) **(revdedcd)**	1	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance. (Refer to appendix table REVDEDCD).
660	REVENUE CENTER RENDERING PHYSICIAN NPI NUM (262) **(revnpi)**	2	The NPI assigned to the revenue center provider. The NPI may not be available prior to 7/1/2007. ***Encrypted Data.**
670	YEAR OF CLAIMS FILE **(year)**	4	Year of the file.
674	RECORD COUNT FOR CLAIM **(rec_count)**	3	Counter for each claim.
677	CLAIM ID **(claim_id)**	10	ID to index unique claims
687	Filler	1	

Note: The number in parenthesis corresponds to the number of the variable on the CMS Version K file documentation.