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 ID **(HICBIC)**	11	Encrypted ID for Non Cancer Patients
12	BENEFICIARY IDENTIFICATION CODE **(BIC)** (12)	2	Relationship between individual and a primary Social Security Administration Beneficiary. (Refer to appendix table BIC)
14	SSA STANDARD STATE CODE (14) **(state_cd)**	2	State of Beneficiary's residence, SSA Standard Code. (Refer to appendix table STATE_CD)
16	SSA STANDARD COUNTY CODE (35) **(cnty_cd)**	3	County of Beneficiary's residence, SSA Standard Code.
19	MAILING CONTACT ZIP CODE (42) **(bene_zip)**	9	Beneficiary's mailing address zip code. ***Encrypted Data. Special Permission required to receive unencrypted data.**
28	CWF MEDICARE STATUS (46) **(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

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COL	FIELD	LENGTH	NOTES
30	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' (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
32	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
40	CLAIM THROUGH DATE (16) **(thru_dtm, thru_dtd, thru_dty)**	8	Last day of Provider's or Physician/ Supplier's billing statement. MMDDYYYY
48	FI NUMBER (39) **(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 NCH & DME)
53	CARRIER CLAIM ENTRY CODE (30) **(entry_cd)**	1	Carrier-generated code describing whether the Part B claim is an original debit, full credit, or replacement debit. 1 = *Original debit 3 = Full credit 5 = Replacement debit 9 = Accrete bill history only (Internal; effective 2/22/91) *if claim disposition code = 3, entry code = 1 means original debit was voided.

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COL	FIELD	LENGTH	NOTES
55	CARRIER CLAIM PROVIDER ASSIGNMENT INDICATOR SWITCH (62) **(asgmntcd)**	1	A switch indicating whether or not the provider accepts assignment for the noninstitutional claim. A = Assigned claim N = Non-assigned claim
56	CARRIER CLAIM REFERRING UPIN NUMBER (60) **(rfr_upin)**	6	Unique Physician Identification Number (UPIN) number of physician who referred beneficiary to physician that performed the Part B services. ***Encrypted data.**
62	CARRIER CLAIM REFERRING PHYSICIAN NPI NUMBER **(rfr_npi)** (61)	10	The NPI assigned to the physician who referred beneficiary to physician that performed the Part B services. The NPI may not be available prior to 7/1/2007. ***Encrypted Data.**
72	LINE HCFA PROVIDER SPEC CODE (136) **(hcfaspec)**	2	HCFA Specialty code used for pricing the service for this line item on the CWFB claim. (Refer to appendix table HCFASPEC)
74	LINE PROVIDER PART. INDICATOR CODE (138) **(prtcptg)**	1	Code indicating whether or not a provider is participating or accepting assignment for this line item on the Part B claim. (Refer to appendix table PRTCPTG).
75	LINE PROCESSING INDICATOR CODE (171) **(proindcd)**	2	The code indicating the reason a line item on the CWFB claim was allowed or denied. (Refer to appendix table PROINDCD).
77	LINE PAYMENT 80%/100% CODE (172) **(pay80cd)**	1	The code indicating that the amount shown in the payment field on the CWFB claim represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only. 0 = 80% 1 = 100% 3 = 100% limitation of liability only 4 = 75% Reimbursement
78	LINE SERVICE DEDUCTIBLE INDICATOR SWITCH (173) **(dedind)**	1	Switch indicating whether or not the service reflected on the line item on the CWFB claim is subject to deductible. 0 = Service subject to deductible 1 = Service not subject to deductible

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COL	FIELD	LENGTH	NOTES
79	LINE PAYMENT INDICATOR CODE (174) **(payindcd)**	1	Code that indicates the payment screen used to determine the allowed charge for the line item on the CWFB claim. (Refer to appendix table PAYINDCD).
80	CARRIER MILES/TIME/UNITS/SERVICES COUNT (175) **(mtuscnt)**	12.3	The count of the total units associated with services needing unit reporting such as transportation, miles anesthesia time units, number of services, volume of oxygen or blood units. This is a line item on the CWFB claim and is used for both allowed and denied services.
92	CARRIER MILES/TIME/UNITS/SERVICES INDICATOR CODE (176) **(mtusind)**	1	Code indicating the units associated with services needing unit reporting on the line item for the CWFB claim. 0 = Values reported as zero (no allowed activities) 1 = Transportation (ambulance) miles 2 = Anesthesia time units 3 = Services 4 = Oxygen units 5 = Units of blood 6 = Anesthesia base and time units (prior to 1991; from BMAD)
93	LINE HCPCS CODE (147) **(hcpcs)**	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)
98	LINE HCPCS INITIAL MODIFIER CODE (148) **(mf1)**	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information File)
100	LINE HCPCS SECOND MODIFIER CODE (149) **(mf2)**	2	Second modifier to enable a more specific procedure ID (Carrier Information File)
102	LINE HCPCS THIRD MODIFIER CODE (150) **(mf3)**	2	
104	LINE HCPCS FOURTH MODIFIER CODE (151) **(mf4)**	2	
106	LINE SUBMITTED CHARGE AMOUNT **(lsubmamt)** (167)	15.2	The amount of submitted charges for the line item service on the non-institutional claim.
121	LINE ALLOWED CHARGE AMOUNT (168) **(lalowamt)**	15.2	The amount of allowed charges reported on the line item on the CWFB claim.

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COL	FIELD	LENGTH	NOTES
136	LINE HCFA TYPE OF SERVICE CODE (141) **(hcfatype)**	1	Carrier's type of service code (usually different from HCFA's) used for pricing this service. (Refer to appendix table HCFATYPE)
137	LINE PLACE OF SERVICE CODE (143) **(plcsrvc)**	2	Place of service for this procedure code. (Refer to appendix table PLCSRVC)
139	LINE FIRST EXPENSE DATE (145) **(frexpenm, frexpend, frexpeny)**	8	Beginning date of this service. (MMDDYYYY)
147	LINE LAST EXPENSE DATE (146) **(lsexpenm, lsexpend, lsexpeny)**	8	Ending date for this service (MMDDYYYY).
155	LINE SERVICE COUNT (140) **(srvc_cnt)**	12	Count of the total number of services processed.
167	LINE DIAGNSOSIS CODE (179) **(linediag)**	7	ICD – 9-CM code indicating diagnosis supporting this procedure/service.
174	LINE PAYMENT AMOUNT (155) **(linepmt)**	15.2	Amount of payment made to provider and/or beneficiary for the services covered
189	LINE BENEFICIARY PART B DEDUCTIBLE AMOUNT (158) **(ldedamt)**	15.2	The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B deductible on the CWFB claim.
204	LINE BENEFICIARY PRIMARY PAYER PAID AMOUNT (160) **(lprpayat)**	15.2	Amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a CWFB claim.
219	LINE BENEFICIARY PRIMARY PAYER CODE (159) **(lprpaycd)**	1	Specifies a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills. (Refer to appendix table PRPAY_CD)
220	LINE BENEFICIARY PAYMENT AMOUNT (156) **(lbenpmt)**	15.2	The payment (reimbursement) made to the beneficiary related to the line item service on the non-institutional claim.
235	LINE PROVIDER PAYMENT AMOUNT (157) **(lprvpmt)**	15.2	The payment made to the provider for the line item service on the non-institutional claim.
250	LINE COINSURANCE AMOUNT (161) **(coinamt)**	15.2	The beneficiary coinsurance liability amount for this line item service on the non-institutional claim.

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COL	FIELD	LENGTH	NOTES
265	LINE INTEREST AMOUNT (163) **(lintamt)**	15.2	Amount of interest to be paid for this line item service on the non-institutional claim.
280	CARRIER CLAIM CASH DEDUCTIBLE APPLIED AMOUNT (68) **(dedapply)**	15.2	The amount of the cash deductible as submitted on the claim.
295	CARRIER CLAIM PRIMARY PAYER PAID AMOUNT (58) **(prpayamt)**	15.2	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.
310	CLAIM PAYMENT AMOUNT (57) **(pmt_amt)**	15.2	Amount of payment made from the Medicare trust fund for the services covered by the claim record.
325	NCH CARRIER CLAIM ALLOWED CHARGE AMOUNT (67) **(allowamt)**	15.2	The total allowed charges on the claim (the sum of line item allowed charges).
340	NCH CARRIER CLAIM SUBMITTED CHARGE AMOUNT (66) **(sbmtamt)**	15.2	The total submitted charges on the claim (the sum of line item submitted charges).
355	NCH CLAIM PROVIDER PAYMENT AMOUNT (63) **(prov_pmt)**	15.2	The total payments made to the provider for this claim (sum of line item provider payment amounts).
370	LINE PRIMARY PAYER ALLOWED CHARGE AMOUNT (164) **(prpyalow)**	15.2	The primary payer allowed charge amount for the line item service on the non-institutional claim.
385	PERFORMING PROVIDER PIN NUMBER (128) **(prf_prfl)**	10	***Encrypted Data.**
399	CARRIER LINE REDUCED PAYMENT PHYSICIAN ASSISTANT CODE (139) **(astnt_cd)**	1	Code that identifies claims that have been paid a reduced fee schedule amount (65%, 75% or 85%) because a physician assistant performed the services. (Refer to appendix table ASTNT_CD).
400	CARRIER CLAIM HCPCS YEAR CODE (69) **(hcpcs_yr)**	1	The terminal digit of HCPCS version used to code the claim.
401	CARRIER REFERRING PIN PHYSICIAN (89) **(rfr_prfl)**	10	***Encrypted Data.**
411	CARRIER LINE PERFORMING UPIN NUMBER (129) **(perupin)**	6	Unique identifier of physician performing the procedure specified by the HCPCS code. ***Encrypted Data.**

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COL	FIELD	LENGTH	NOTES
417	CARRIER LINE PERFORMING NPI NUMBER (130) **(prf_npi)**	10	The NPI assigned to the performing provider. The NPI may not be available prior to 7/1/2007. ***Encrypted Data.**
427	LINE PERFORMING GROUP NPI (131) **(prgrp_npi)**	10	The NPI assigned to the performing provider. The NPI may not be available prior to 7/1/2007. ***Encrypted Data.**
437	CARRIER LINE PROVIDER TYPE CODE (132) **(prv_type)**	1	Code identifying the type of provider furnishing the service for this line item on the Part B claim. (Refer to appendix table PRV_TYPE)
438	LINE NCH PROVIDER STATE CODE (134) **(prvstate)**	2	SSA State code where provider facility is located. (Refer to appendix table STATE_CD)
440	CARRIER LINE PERFORMING PROVIDER ZIP CODE (135) **(prozip)**	9	Zip code of the physician/ supplier who performed the Part B service for this line item. ***Encrypted data. Special permission required for unencrypted data.**
449	CARRIER CLAIM LINE COUNT (101) **(clinecnt)**	2	The count of the number of line items reported on the carrier claim.
478	CLAIM PRINCIPAL DIAGNOSIS CODE (53) **(pdgns_cd)**	7	The diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.
485	CARRIER CLAIM DIAGNOSIS CODE J COUNT (100) **(cdgncnt)**	2	The count of the number of diagnosis codes reported on the carrier claim.
487	CLAIM DIAGNOSIS CODES (125) **(dgn_cd-1-dgn_cd12)**	12*7	Up to twelve 5 digit ICD-9 diagnosis codes. For persons with less than twelve codes the columns are blank filled.
574	CARRIER CLAIM BENEFICIARY PAID AMOUNT (65) **(benepaid)**	15.2	The amount paid to the beneficiary for the non-institutional Part B services.
597	NCH CLAIM BENEFICIARY PAYMENT AMOUNT (64) **(nchben_pmt)**	15.2	The total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary).
612	CLAIM CLINICAL TRIAL NUMBER (73) **(cln_tril)**	8	The number used to identify all items and services provided to a beneficiary during their participation in a clinical trial.

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COL	FIELD	LENGTH	NOTES
620	CARRIER LINE ANESTHESIA BASE UNIT COUNT (180) **(ansthcnt)**	12	The base number of units assigned to the line item anesthesia procedure on the carrier claim (non-DMERC).
632	CARRIER LINE CLINICAL LAB CHARGE AMT (170) **(llabamt)**	15.2	Fee schedule charge amount applied for the line item clinical laboratory service on the carrier claim (non-DMERC).
647	CARRIER LINE CLINICAL LAB NUM (169) **(llab_num)**	10	The identification number assigned to the clinical laboratory providing services for the line item on the carrier claim (non-DMERC).
657	CARRIER LINE PRICING LOCALITY CODE (144) **(price_cd)**	2	Code denoting the carrier-specific locality used for pricing the service for this line item on the carrier claim (non-DMERC).
659	CARRIER LINE PSYCHIATRIC, OCCUPATIONAL THERAPY, PHYSICAL THERAPY LIMIT AMOUNT (162) **(psych_lmt)**	15.2	For type of service psychiatric, occupational therapy or physical therapy, the amount of allowed charges applied toward the limit cap for this line item service on the non-institutional claim.
674	LINE IDE NUMBER (153) **(ide_num)**	7	The exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device.
681	LINE PROVIDER TAX NUMBER (133) **(tax_num)**	10	Social security number or employee identification number of physician/supplier used to identify to whom payment is made for the line item service on the non-institutional claim. **Encrypted data.**
700	CARRIER LINE RX NUMBER (191) **(lrx_num)**	30	The number used to identify the prescription order number for drugs and biological purchased through the competitive acquisition program (CAP).
730	LINE DUPLICATE CLAIM CHECK INDICATOR CODE (187) **(dup_chk)**	1	The code used to identify an item or service that appeared to be a duplicate but has been reviewed by a carrier and appropriately approved for payment. 1 = Suspect duplicate review performed
731	LINE HEMATOCRIT/HEMOGLOBIN RESULT NUMBER (193) **(hgb_rslt)**	4	The number used to identify the most recent hematocrit or hemoglobin reading on the non-institutional claim.

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COL	FIELD	LENGTH	NOTES
735	LINE HEMATOCRIT/HEMOGLOBIN TEST TYPE CODE (192) **(hgb_type)**	2	The code used to identify which reading is reflected in the hematocrit/hemoglobin result number field on the non-institutional claim. R1 = Hemoglobin Test R2 = Hematocrit Test
737	YEAR OF FILE **(year)**	4	Year of the file
741	RECORD COUNT **(rec_count)**	3	Record count for claim
744	CLAIM ID **(claim_id)**	10	ID to index unique claims
754	CARRIER CLAIM PAYMENT DENIAL CODE (55) **(pmtdnlcd)**	2	Indicates to whom payment was made, or if a claim was denied. (Refer to appendix table PMTDNLCD)
756	HPSA/SCARCITY INDICATOR CODE (190) **(hscrcty)**	1	(Refer to appendix table HSCRCTY)
757	Filler	1	

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