

<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
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	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

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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
60	CLAIM TOTAL LINE COUNT (26) (linecnt)	2	The count of the number of line items on the carrier claim.
63	CARRIER CLAIM ENTRY CODE (30) (entry_cd)	1	Generated by Carrier. 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.
64	BENEFICIARY RESIDENCE SSA STANDARD COUNTY CODE (35) (cnty_cd)	3	County of Beneficiary's residence, SSA Standard Code.
67	CARRIER NUMBER (39) (carr_num)	5	Assigned by CMS to an Intermediary or Carrier authorized to process claims from Providers or Physician/Suppliers. (Refer to appendix table CARR_NUM)
72	BENEFICIARY MAILING CONTACT ZIP CODE (42) (bene_zip)	9	Beneficiary's mailing address zip code. *Encrypted data. Special permission required for unencrypted data.
81	CWF BENEFICIARY MEDICARE STATUS CODE (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
83	CLAIM PRINCIPAL DIAGNOSIS VERSION CODE (52) (pdvrsncd)	1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10

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84	CLAIM PRINCIPAL DIAGNOSIS CODE (53) (pdgns_cd)	7	Beneficiaries' principal diagnosis code.
91	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)
93	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.
108	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.
123	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.
129	CARRIER CLAIM REFERRING PHYSICIAN NPI NUMBER (61) (rfr_npi)	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.
139	CARRIER CLAIM PROVIDER ASSIGNMENT INDICATOR SWITCH (62) (asgmtcd)	1	A switch indicating whether or not the provider accepts assignment for the noninstitutional claim A = Assigned claim N = Non-assigned claim
140	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).
155	NCH CLAIM BENEFICIARY PAYMENT AMOUNT (64) (bene_pmt)	15.2	The total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.)
170	CARRIER CLAIM BENEFICIARY PAID AMOUNT (65) (benepaid)	15.2	The amount paid by the beneficiary for the non-institutional Part B services.
185	NCH CARRIER CLAIM SUBMITTED CHARGE AMOUNT (66) (sbmtchrg)	15.2	The total allowed charges on the claim (the sum of line item allowed charges).

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200	NCH CLAIM ALLOWED CHARGE AMOUNT (67) (alowchrg)	15.2	The total allowed charges on the claim (the sum of line item allowed charges).
215	CARRIER CLAIM CASH DEDUCTIBLE APPLIED AMOUNT (68) (dedapply)	15.2	The amount of the cash deductible as submitted on the claim.
230	CARRIER CLAIM HCPCS YEAR CODE (69) (hcpcs_yr)	1	The terminal digit of HCPCS version used to code the claim.
231	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.
239	CARRIER CLAIM REFERRING PIN NUMBER (93) (rfr_prfl)	10	*Encrypted Data.
249	CLAIM DIAGNOSIS CODE J COUNT (104) (cdgncnt)	2	The count of the number of diagnosis codes (both principal and secondary) reported on a DMERC claim. The purpose of this count is to indicate how many claim diagnosis code trailers are present.
251	CLAIM DIAGNOSIS VERSION CODE (128) (dvrscd1-dvrscd12)	12*1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10
263	CLAIM DIAGNOSIS CODE (129) (dgns_cd1-dgns_cd12)	12*7	Up to twelve 7 digit ICD diagnosis codes. For persons with less than twelve codes the columns are blank filled.
347	PERFORMING PROVIDER PIN NUMBER (132) (prf_prfl)	10	*Encrypted Data.
357	CARRIER LINE PERFORMING UPIN NUMBER (133) (prf_upin)	6	Unique identifier of physician performing the procedure specified by the HCPCS code. *Encrypted Data.
363	CARRIER LINE PERFORMING NPI NUMBER (134) (prfnpi)	10	The NPI assigned to the performing provider. The NPI may not be available prior to 7/1/2007. *Encrypted Data.
373	CARRIER LINE PERFORMING GROUP NPI NUMBER (135) (prgrpnpi)	10	The NPI assigned to the performing provider group practice. The NPI may not be available prior to 7/1/2007. *Encrypted Data.
383	CARRIER LINE PROVIDER TYPE CODE (136) (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)

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384	LINE PROVIDER TAX NUMBER (137) (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.
394	LINE NCH PROVIDER STATE CODE (138) (prvstate)	2	SSA State code where provider facility is located. (Refer to appendix table STATE_CD)
396	CARRIER LINE PERFORMING PROVIDER ZIP CODE (139) (provzip)	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.
405	LINE HCFA PROVIDER SPECIALTY CODE (140) (hcfaspcl)	2	HCFA Specialty code used for pricing the service for this line item on the CWFB claim. (Refer to appendix table HCFASPCL)
407	LINE PROVIDER PARTICIPATING INDICATOR CODE (142) (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).
408	CARRIER LINE REDUCED PAYMENT PHYSICIAN ASSISTANT CODE (143) (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).
409	LINE SERVICE COUNT (144) (srvc_cnt)	12.3	Count of the total number of services processed.
421	LINE HCFA TYPE SERVICE CODE (145) (typsrvcb)	1	Carrier's type of service code (usually different from HCFA's) used for pricing this service. (Refer to appendix table TYPsrvcB)
422	LINE PLACE OF SERVICE CODE (147) (plcsrvc)	2	Place of service for this procedure code. (Refer to appendix table PLCSRVC)
424	CARRIER LINE PRICING LOCALITY CODE (148) (lclty_cd)	2	Code denoting the carrier-specific locality used for pricing the service for this line item on the carrier claim (non-DMERC).
426	LINE FIRST EXPENSE DATE (149) (expnsdt1m, expnsdt1d, expnsdt1y)	8	Beginning date of this service. MMDDYYYY
434	LINE LAST EXPENSE DATE (150) (expnsdt2m, expnsdt2d, expnsdt2y)	8	Ending date for this service. MMDDYYYY

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442	LINE HCPCS CODE (151) (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)
447	LINE HCPCS INITIAL MODIFIER CODE (152) (mdfr_cd1)	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information File)
449	LINE HCPCS SECOND MODIFIER CODE (153) (mdfr_cd2)	2	Second modifier to enable a more specific procedure ID (Carrier Information File)
451	LINE HCPCS THIRD MODIFIER CODE (154) (mdfr_cd3)	2	Third modifier to the HCPCS procedure code used to process the DMERC line item.
453	LINE HCPCS FOURTH MODIFIER CODE (155) (mdfr_cd4)	2	Fourth modifier to the HCPCS procedure code used to process the DMERC line item.
455	LINE IDE NUMBER (157) (line_ide)	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.
462	LINE NCH PAYMENT AMOUNT (159) (linepmt)	15.2	Amount of payment made to provider and/or beneficiary for the services covered
477	LINE BENEFICIARY PAYMENT AMOUNT (160) (lbenpmt)	15.2	The payment (reimbursement) made to the beneficiary related to the line item service on the non-institutional claim.
492	LINE PROVIDER PAYMENT AMOUNT (161) (lprvpmt)	15.2	The payment made to the provider for the line item service on the non-institutional claim.
507	LINE BENEFICIARY PART B DEDUCTIBLE AMOUNT (162) (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.
522	LINE BENEFICIARY PRIMARY PAYER CODE (163) (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)

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523	LINE BENEFICIARY PRIMARY PAYER PAID AMOUNT (164) (lprpdamt)	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.
538	LINE COINSURANCE AMOUNT (165) (coinamt)	15.2	The payment made to the provider for the line item service on the non-institutional claim.
553	CARRIER LINE PSYCHIATRIC, OCCUPATIONAL THERAPY, PHYSICAL THERAPY LIMIT AMOUNT (166) (llmtamt)	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.
568	LINE INTEREST AMOUNT (167) (lint_amt)	15.2	Amount of interest to be paid on this line item.
583	LINE PRIMARY PAYER ALLOWED CHARGE AMOUNT (168) (prpyalow)	15.2	The primary payer allowed charge amount for the line item service on the non-institutional claim.
598	LINE SUBMITTED CHARGE AMOUNT (171) (lsbmtchg)	15.2	The amount of submitted charges reported on the line item on the CWFB claim.
613	LINE ALLOWED CHARGE AMOUNT (172) (lalowchg)	15.2	The amount of allowed charges reported on the line item on the CWFB claim.
628	CARRIER LINE CLINICAL LAB NUM (173) (lab_num)	10	The identification number assigned to the clinical laboratory providing services for the line item on the carrier claim (non-DMERC).
638	CARRIER LINE CLINICAL LAB CHARGE AMT (174) (lab_amt)	15.2	Fee schedule charge amount applied for the line item clinical laboratory service on the carrier claim (non-DMERC).
653	LINE PROCESSING INDICATOR CODE (175) (prcngind)	2	The code indicating the reason a line item on the CWFB claim was allowed or denied. (Refer to appendix table PRCNGIND).
655	LINE PAYMENT 80%/100% CODE (176) (pmtindsw)	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

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656	LINE SERVICE DEDUCTIBLE INDICATOR SWITCH (177) (ded_sw)	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
657	LINE PAYMENT INDICATOR CODE (178) (pmtindcd)	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 PMTINDCD).
658	CARRIER LINE MILES/TIME/UNITS/SERVICES COUNT (179) (mtus_cnt)	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.
670	CARRIER LINE MILES/TIME/UNITS/SERVICES INDICATOR CODE (180) (mtus_ind)	1	Code indicating the units associated with services needing unit reporting on the line item for the CWFB claim. 0 = Values reported as zero 3 = Number of services 4 = Oxygen volume units 6 = Drug Dosage – since early 1994 this value has incorrectly been placed on DMERC claims. The DMERCs were overriding the MTUS indicator with a ‘6’ if the claim was submitted with an NDC code. NOTE: It was recently discovered that this problem has been corrected – no date on when the correction became effective.
671	LINE DIAGNOSIS VERSION CODE (182) (ldvrsncd)	1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10
672	LINE DIAGNOSIS CODE (183) (linedgns)	7	ICD code indicating diagnosis supporting this procedure/service.
679	CARRIER LINE ANESTHESIA BASE UNIT COUNT (184) (ansthunt)	12	The base number of units assigned to the line item anesthesia procedure on the carrier claim (non-DMERC).
691	LINE DUPLICATE CLAIM CHECK INDICATOR CODE (191) (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

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692	CARRIER LINE HPSA/SCARCITY INDICATOR CODE (194) (hscrcty)	1	(Refer to appendix table HSCRCTY)
693	CARRIER LINE RX NUMBER (195) (rx_num)	30	The number used to identify the prescription order number for drugs and biological purchased through the competitive acquisition program (CAP).
723	LINE HEMATOCRIT/ HEMOGLOBIN TEST TYPE CODE (196) (htypecd)	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
725	LINE HEMATOCRIT/ HEMOGLOBIN RESULT NUMBER (197) (hrslnum)	4.1	The number used to identify the most recent hematocrit or hemoglobin reading on the non-institutional claim.
729	YEAR OF CLAIMS FILE (year)	4	Year of the file
733	RECORD COUNT FOR CLAIM (rec_count)	3	Record count for claim
736	CLAIM ID (claim_id)	10	ID to index unique claims
746	Filler	1	

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