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

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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	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.
66	CLAIM SEGMENT LINE COUNT (29) **(sgmtline)**	2	The count used to identify the number of lines on a record/segment.

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COL	FIELD	LENGTH	NOTES
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).

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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.**

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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	CLAIM MCO PAID SWITCH (92) **(mcopdsw)**	1	A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim. 1 = MCO has paid the provider for a claim Blank or 0 = MCO has not paid the provider for a claim
185	CLAIM TREATMENT AUTHORIZATION NUMBER (93) **(authrztn)**	18	The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case.
203	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)
205	CLAIM 1ST DIAGNOSIS E VERSION CODE (100) **(e1vrsncd)**	1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10
206	CLAIM 1ST DIAGNOSIS E CODE (101) **(dgns_e)**	7	The code used to identify the 1st external cause of injury, poisoning, or other adverse effect. This diagnosis E code is also stored as the 1st occurrence of the diagnosis E code trailer.

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COL	FIELD	LENGTH	NOTES
213	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)
214	CLAIM TOTAL CHARGE AMOUNT (103) **(tot_chrg)**	15.2	Total charges for all services included on the institutional claim.
229	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+.
238	OUTPATIENT REVENUE CENTER CODE COUNT (151) **(oprevcnt)**	2	The count of the number of revenue codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many revenue center trailers are present.
240	CLAIM OUTPATIENT SERVICE TYPE CODE (154) **(opsrvtyp)**	1	Code indicating type and priority of outpatient service. (Refer to appendix table OPSRVTYP)
241	CLAIM OUTPATIENT REFERRAL CODE (155) **(op_rfrl)**	1	The code indicating the means by which the beneficiary was referred for outpatient services. (Refer to appendix table OP_RFRL)
242	NCH BENEFICIARY BLOOD DEDUCTIBLE LIABILITY AMOUNT (156) **(blddedam)**	15.2	The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible.
257	NCH BENEFICIARY PART B DEDUCTIBLE AMOUNT (157) **(ptb_ded)**	15.2	Beneficiary's liability for Part B cash deductible as determined by intermediary or Carrier.
272	NCH BENEFICIARY PART B COINSURANCE AMOUNT (158) **(ptb_coin)**	15.2	Beneficiary's liability for Part B coinsurance as determined by intermediary.
287	CLAIM OUTPATIENT PROVIDER PAYMENT AMOUNT (161) **(prvdrpmt)**	15.2	The amount paid, from the Medicare trust fund, to the provider for the services reported on the outpatient claim.
302	NCH BLOOD PINTS FURNISHED QUANTITY (163) **(bldfrnsh)**	3	Number of whole pints of blood furnished to the beneficiary.
305	NCH BLOOD DEDUCTIBLE PINTS QUANTITY (166) **(blddedpt)**	3	The quantity of blood pints applied (blood deductible).

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COL	FIELD	LENGTH	NOTES
308	CLAIM OUTPATIENT TRANSACTION TYPE CODE (167) **(trantype)**	1	The code derived at CWF based on type of bill and provider number to identify the outpatient transaction type. (Refer to appendix table TRANTYPE).
309	CLAIM SERVICE LOCATION NPI NUMBER (182) **(srvcnpi)**	10	The NPI assigned to the service location. The NPI may not be available prior to 1/1/2014. ***Encrypted Data**
319	NCH EDIT TRAILER INDICATOR CODE (187) **(editind)**	1	The code indicating the presence of an NCH edit trailer. E = Edit code trailer present
320	NCH EDIT CODE (188) **(edit_cd)**	4	The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.
324	CLAIM DIAGNOSIS VERSION CODE (206) **(dvrsncd1-dvrsncd25)**	25*1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10
349	CLAIM DIAGNOSIS CODE (207) **(dgns_cd1-dgns_cd25)**	25*7	ICD-9-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.
524	CLAIM DIAGNOSIS VERSION E CODE (210) **(evrsncd1-evrsncd6)**	6*1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10
530	CLAIM DIAGNOSIS E CODE (211) **(edgnsd1-edgnscd6)**	6*7	The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).
572	CLAIM PROCEDURE VERSION CODE (214) **(pvrsncd1-pvrsncd13)**	13*1	ICD procedure version code: 9 = ICD-9 0 = ICD-10
585	CLAIM PROCEDURE CODE (215) **(prcdr_cd1-prcdr_cd13)**	13*7	ICD-9-CM code that indicates the principal or other procedure performed during the period covered by the institutional claim.
676	CLAIM PROCEDURE PERFORMED DATE (216) **(prcdr_dtm1-13, prcdr_dtd1-13, prcdr_dty1-13)**	13*8	On an institutional claim, the date on which the principal or other procedure was performed. MMDDYYYY
780	CLAIM RELATED CONDITION CODE (219) **(rlt_cond1-rlt_cond 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)

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COL	FIELD	LENGTH	NOTES
784	CLAIM RELATED OCCURRENCE CODE (222) **(ocrnc_cd1- ocrnc_cd14)**	14*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)
812	CLAIM RELATED OCCURRENCE DATE 1 (223) **(ocrncdtm1-14, ocrncdtd1-14, ocrncdty1-14)**	14*8	The date associated with the significant event related to an institutional claim that may affect payer processing. MMDDYYYY
924	REVENUE CENTER CODE (235) **(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)
928	REVENUE CENTER DATE (236) **(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
936	REVENUE CENTER 1ST ANSI CODE (237) **(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)
941	REVENUE CENTER APC/HIPPS (241) **(apchipps)**	5	This field was created to house two pieces of data. The Ambulatory Payment Classification (APC) code and the HIPPS code. (Refer to appendix table HCPCS_CD)
946	REVENUE CENTER HEALTHCARE COMMON PROCEDURE CODING SYSTEM (242) **(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)
951	REVENUE CENTER HCPCS INITIAL MODIFIER CODE (243) **(mdfr_cd1)**	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information file)

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COL	FIELD	LENGTH	NOTES
953	REVENUE CENTER HCPCS SECOND MODIFIER CODE (244) **(mdfr_cd2)**	2	Second modifier to the procedure code to enable a more specific procedure ID. (Carrier Information file)
955	REVENUE CENTER HCPCS THIRD MODIFIER CODE (245) **(mdfr_cd3)**	2	Third modifier to the procedure code to enable a more specific procedure ID. (Carrier Information file)
957	REVENUE CENTER PAYMENT METHOD INDICATOR CODE (248) **(pmtmthd)**	2	The code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator. (Refer to appendix table PMTMTHD)
959	REVENUE CENTER DISCOUNT INDICATOR CODE (249) **(dscntind)**	1	The code used to identify those services that are packaged/bundled with another service. (Refer to appendix table DSCNTIND)
960	REVENUE CENTER PACKAGING INDICATOR CODE (250) **(packgind)**	1	The code used to identify those services that are packaged/bundled with another service. (Refer to appendix table PACKGIND)
961	REVENUE CENTER PRICING INDICATOR CODE (251) **(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)
962	REVENUE CENTER IDE, NDC, UPC NUMBER (253) **(idendc)**	24	Revenue Center IDE, NDC, UPC number
987	REVENUE CENTER NDC QUANTITY QUALIFIER CODE (254) **(qtyqlfr)**	2	The code used to indicate the unit of measurement for the drug that was administered. (Refer to appendix table QTYQLFR)
989	REVENUE CENTER NDC QUANTITY (255) **(ndcqty)**	12.3	The quantity dispensed for the drug reflected on the revenue center line item.
1004	REVENUE CENTER UNIT COUNT (256) **(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.
1012	REVENUE CENTER RATE AMOUNT (257) **(rev_rate)**	15.2	Charges relating to unit cost associated with the revenue center code.
1027	REVENUE CENTER CASH DEDUCTIBLE AMOUNT (259) **(revdctbl)**	15.2	The amount of cash deductible the beneficiary paid for the line item service.

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COL	FIELD	LENGTH	NOTES
1042	REVENUE CENTER COINSURANCE/WAGE ADJUSTED COINSURANCE AMOUNT (260) **(wageadj)**	15.2	The amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.
1057	REVENUE CENTER 1ST MEDICARE SECONDARY PAYER PAID AMOUNT (262) **(rev_msp1)**	15.2	The amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary).
1072	REVENUE CENTER PROVIDER PAYMENT AMOUNT (264) **(rprvdpmt)**	15.2	The amount paid to the provider for the services reported on the line item.
1087	REVENUE CENTER PATIENT RESPONSIBILITY PAYMENT AMOUNT (266) **(ptntresp)**	15.2	The amount paid by the beneficiary to the provider for the line item service.
1102	REVENUE CENTER PAYMENT AMOUNT (267) **(revpmt)**	15.2	Medicare payment amount for the specific revenue center.
1117	REVENUE CENTER TOTAL CHARGE AMOUNT (268) **(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.
1132	REVENUE CENTER NON-COVERED CHARGE AMOUNT (269) **(rev_ncvr)**	15.2	The charge amount related to a revenue center code for services that are not covered by Medicare.
1147	REVENUE CENTER DEDUCTIBLE COINSURANCE CODE (270) **(revdedcd)**	1	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance. (Refer to appendix table REVDEDCD).
1148	REVENUE CENTER STATUS INDICATOR CODE (272) **(rstusind)**	2	The code used to identify the status of the line item service. This field along with the payment method indicator field is used to identify how the service was priced for payment. (Refer to appendix table RSTUSIND)

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COL	FIELD	LENGTH	NOTES
1150	REVENUE CENTER DUPLICATE CLAIM CHECK INDICATOR CODE (273) **(dup_chk)**	1	The code used to identify an item or service that appeared to be a duplicate but has been reviewed by an FI or MAC and appropriately approved for payment. 1 = Suspect duplicate review performed
1151	YEAR OF CLAIMS FILE **(year)**	4	Year of the file
1155	RECORD COUNT FOR CLAIM **(rec_count)**	3	Counter for each claim
1158	CLAIM ID **(claim_id)**	10	ID to index unique claims
1168	Filler	1	

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