for

Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)

The Green Mountain Care Board is the steward of the Vermont Healthcare Claims Uniform Reporting and Evaluation System ("VHCURES") which contains information related to health care utilization, costs, and resources provided in Vermont and to Vermont residents in other states. Under the statutory authority to collect these data (18 V.S.A. § 9410), the Vermont Green Mountain Care Board (GMCB) administers the program.

Health insurers, health care providers, hospitals and other health care facilities, and governmental agencies must submit reports, data, schedules, statistics, and other information specified by the Board for inclusion in the health care database. This reporting manual, as a companion to Green Mountain Care Board Rule 8.000, specifies data submission requirements for the VHCURES data set, including the required data submission schedule, required fields, file layouts, file components, edit specifications, instructions, and other technical information.

Data Submission Schedule

The reporting period for submission of each specified file listed in this Manual shall be determined on a separate basis for Vermont members and non-resident members by the highest total number of Vermont resident members or non-resident members receiving covered services provided by Vermont providers or facilities for which claims are being paid for any one month of the calendar year. Data files are to be submitted in accordance with the following schedule:

Total # of Members	Reporting Period	Reporting Schedule
≥ 2,000	Monthly	Prior to the end of the month following the month in which claims were paid
500 – 1,999	Quarterly	Prior to April 30, July 31, October 31, January 31 for each preceding calendar quarter in which claims were paid
200 - 499	Annually	Prior to April 30 of the following year for the preceding twelve months in which claims were paid
< 200	N/A	

Data Element #	Element	Required Start Date	Type	Maximum Length	Hashed?
ME001	Submitter code	1/31/2007	Text	8	
ME002	National Plan ID	1/31/2007	Text	30	
ME003	Insurance Type Code/Product	1/31/2007	Text	2	

Data Element #	Element	Required Start Date	Type	Maximum Length	Hashed?
ME003 (Cont'd.)	Insurance Type Code/Product				
ME004	Year	1/31/2007	Integer	4	
ME005	Month	1/31/2007	Text	2	
ME006	Insured Group or Policy Number	1/31/2007	Text	30	
ME007	Coverage Level Code	1/31/2007	Text	3	
ME008	Subscriber Unique Identification Number	1/31/2007	Text	9	Y
ME009	Plan Specific Contract Number	1/31/2007	Text	80	Y
ME010	Member Suffix or Sequence Number	1/31/2007	Integer	20	
ME011	Member Social Security Number	1/31/2007	Text	9	Y

Data Element #	Element	Required Start Date	Type	Maximum Length	Hashed?
ME012	Individual Relationship Code	1/31/2007	Text	2	
ME013	Member Gender	1/31/2007	Text	1	
ME014	Member Date of Birth	1/31/2007	Date	8	
ME015	Member City Name	1/31/2007	Text	30	
ME016	Member State or Province	1/31/2007	Text	2	
ME017	Member ZIP Code	1/31/2007	Text	11	
ME018	Medical Coverage	1/31/2007	Text	1	
ME019	Prescription Drug Coverage	1/31/2007	Text	1	
ME020	Dental Coverage Flag	2019	Text	1	
ME021	Placeholder		Text	6	
ME022	Placeholder		Text	6	

Data Element #	Element	Required Start Date	Type	Maximum Length	Hashed?
ME023	Placeholder		Text	15	
ME024	Placeholder		Text	1	
ME025	Placeholder		Text	6	
ME026	Placeholder		Text	6	

Data Element #	Element	Required Start Date	Type	Maximum Length	Hashed?
ME027	Placeholder		Text	20	
ME028	Primary Insurance Indicator	1/31/2007	Text	1	
ME029	Coverage Type	1/31/2007	Text	3	
ME030	Market Category Code	1/31/2007	Text	4	

Data Element #	Element	Required Start Date	Type	Maximum Length	Hashed?
ME031	Blueprint Medical Home (BPMH) Indicator / Vermont ACO Participation Indicator	04/2018	Text	2	
ME032	Group Name		Text	100	
ME101	Subscriber Last Name	1/31/2007	Text	60	Y
ME102	Subscriber First Name	1/31/2007	Text	35	Y
ME103	Subscriber Middle Initial	1/31/2007	Text	1	Y
ME104	Member Last Name	1/31/2007	Text	60	Y
ME105	Member First Name	1/31/2007	Text	35	Y
ME106	Member Middle Initial	1/31/2007	Text	1	Y

Data Element #	Element	Required Start Date	Type	Maximum Length	Hashed?
ME899	Record Type	1/31/2007	Text	2	

Description/Codes/Sources

Payer submitting payments

CMS National Plan ID

12 Medicare Secondary Working Aged Beneficiary or Spouse with
     Employer Group Health Plan
13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12
     month coordination period with an employer's group health plan
14 Medicare Secondary, No-fault insurance including Auto is primary
15 Medicare Secondary Worker's Compensation
16 Medicare Secondary Public Health Service or Other Federal Agency
41 Medicare Secondary Black Lung
42 Medicare Secondary Veteran's Administration
43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large
     Group Health Plan (LGHP)
47 Medicare Secondary, Other Liability Insurance is Primary
CP Medicare Conditionally Primary
EP Exclusive Provider Organization
HM Health Maintenance Organization (HMO)
HN Health Maintenance Organization (HMO) Medicare Advantage
HS Special Low Income Medicare Beneficiary
IN   Indemnity
MA Medicare Part A
MB Medicare Part B
MD Medicare Part D
MC Medicaid
MH Medigap Part A
MI   Medigap Part B
MP Medicare Primary
PC Personal Care
PE Property Insurance - Personal

Description/Codes/Sources

PR Preferred Provider Organization (PPO)
PS Point of Service (POS)
QM Qualified Medicare Beneficiary
SP Supplemental Policy

Year for which eligibility is reported in this submission

Month for which eligibility is reported in this submission

Group or policy number - not the number that uniquely identifies the
subscriber

Benefit coverage level
CHD Children Only
DEP Dependents Only
ECH Employee and Children
EMP Employee Only
ESP Employee and Spouse
FAM Family
IND Individual
SPC Spouse and Children
SPO Spouse Only

The subscriber's social security number; used to create
unique member ID. Set as null if unavailable.

The plan assigned contract number.
Set as null if contract number equals subscriber's social security number.

Unique number of the member within the contract.

Member's social security number; used to create unique
member ID. Set as null if unavailable.

Description/Codes/Sources

Member's relationship to insured as shown below:
01 Spouse
18 Self/Employee
19 Child
20 Employee
21 Unknown
39 Organ donor
40 Cadaver donor
53 Life Partner
G8 Other Relationship

M Male
F Female
U Unknown

YYYYMMDD

The city location of the member.

As defined by the US Postal Service

ZIP Code of member - may include non-US codes. Do not include dash

Y Yes – must be mutually exclusive with MC019
N No

Y Yes – must be mutually exclusive with MC018
N No

Use this field to report whether or not the member had dental coverage
during the reported period. The only valid codes for this field are:

Y = Yes
N = No

Used and or proposed by other states for - Race 1.

Used and or proposed by other states for - Race 2.

Description/Codes/Sources

Used and or proposed by other states for – Other Race.

Used and or proposed by other states for – Hispanic indicator.

Used and or proposed by other states for – Ethnicity 1.

Used and or proposed by other states for – Ethnicity 2.

Description/Codes/Sources

Used and or proposed by other states for – Other Ethnicity.

1 Yes, primary insurance
2 No, secondary or tertiary insurance

ASW   for self-funded plans that are administered by a third party
         administrator, where the employer has purchased stop-loss, or
         group excess, insurance coverage
ASO   for self funded plans that are administered by a third-party
         administrator, where the employer has not purchased stop-loss, or
         group excess insurance coverage
STN   for short-term non-renewable health insurance.
UND   for plans underwritten by the insurer
OTH   for any other plan. Insurers using this code shall obtain prior
         approval from BISHCA

IND   for policies sold and issued directly to individuals. (Non-group)
FCH   or policies sold and issued directly to individuals on a franchise
         basis.
GCV   for policies sold and issued directly to individuals as group
         conversion policies.
GS1   for policies sold and issued directly to employers having exactly
         one employee
GS2   for policies sold and issued directly to employers having between
         two and nine employees
GS3   for policies sold and issued directly to employers having between
         10 and 25 employees
GS4   for policies sold and issued directly to employers having between
         26 and 50 employees
GLG1 for policies sold and issued directly to employers having between
          51 and 99 employees
GLG2 for policies sold and issued directly to employers having 100 or
           more employees
GSA   for policies sold and issued directly to small employers through a
         qualified association trust
OTH   For policies sold to other types of entities. Insurers using this
         market code shall obtain prior approval from BISHCA

Description/Codes/Sources

Use this field to report both the Vermont Blueprint Medical Home (BPMH) Indicator and the Vermont ACO Participation Indicator. Use the first character in the field to report whether or not the member was a participant in the Vermont Blueprint for Health's medical home initiative. Use the second character in the field to report whether or not the member was a participant in a Vermont accountable care organization (ACO).

Submitters participating in the Blueprint medical home initiative should use the following codes for the first character in the field:
2 = Member attributed to a Blueprint medical home
1 = Member not attributed to a Blueprint medical home

Non-participating submitters should use:
0 = Information not available due to non-participation in the Blueprint medical home initiative

Only those submitters reporting participation in a Vermont ACO should use the following codes for the second character in the field:
A = Not attributed to an ACO
B = Attributed to the OneCare ACO
C = Attributed to the CHAC ACO

Use this field to report the name of the group that covers the member.

Notes: If a policy is sold to an individual as a non-group policy, then both the "Insured Group or Policy Number" field (ME006) and this "Group Name" field (ME032) should be reported with a value of "IND".

The subscriber last name.

The subscriber first name.

The subscriber middle initial.

The member last name.

The member first name.

The member middle initial.

Description/Codes/Sources

Value = ME

Data Element #	Element	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
ME001	Payer	N/A
ME002	National Plan ID	N/A
ME003	Insurance Type Code/Product	271/2110C/EB/ /04, 271/2110D/EB/ /04
ME004	Year	N/A
ME005	Month	N/A
ME006	Insured Group or Policy Number	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02
ME007	Coverage Level Code	271/2110C/EB/ /02, 271/2110D/EB/ /02
ME008	Subscriber Unique Identification Number	271/2100C/REF/SY/02
ME009	Plan Specific Contract Number	271/2100C/NM1/MI/09
ME010	Member Suffix or Sequence Number	N/A
ME011	Member Identification Code	271/2100C/REF/SY/02, 271/2100D/REF/SY/02
ME012	Individual Relationship Code	271/2100C/INS/Y/02, 271/2100D/INS/N/02
ME013	Member Gender	271/2100C/DMG/ /03, 271/2100D/DMG/ /03
ME014	Member Date of Birth	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02
ME015	Member City Name	271/2100C/N4/ /01, 271/2100D/N4/ /01
ME016	Member State or Province	271/2100C/N4/ /02, 271/2100D/N4/ /02
ME017	Member ZIP Code	271/2100C/N4/ /03, 271/2100D/N4/ /03
ME018	Medical Coverage	N/A
ME019	Prescription Drug Coverage	N/A
ME020	Dental Coverage Flag	N/A
ME021	Placeholder	N/A
ME022	Placeholder	N/A
ME023	Placeholder	N/A
ME024	Placeholder	N/A
ME025	Placeholder	N/A
ME026	Placeholder	N/A

Data Element #	Element	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
ME027	Placeholder	N/A
ME028	Primary Insurance Indicator	N/A
ME029	Coverage Type	N/A
ME030	Market Category Code	N/A
ME031	Blueprint Medical Home (BPMH) Indicator / Vermont ACO Participation Indicator	N/A
ME032	Group Name	834/2100D/NM1/36/03
ME101	Subscriber Last Name	271/2100C/NM1/ /03
ME102	Subscriber First Name	271/2100C/NM1/ /04
ME103	Subscriber Middle Initial	271/2100C/NM1/ / 05
ME104	Member Last Name	271/2100C/NM1/ /03, 271/2100D/NM1/ /03
ME105	Member First Name	271/2100C/NM1/ /04, 271/2100D/NM1/ /04
ME106	Member Middle Initial	271/2100C/NM1/ /05, 271/2100D/NM1/ /05
ME899	Record Type	N/A

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC001	Submitter Code	1/31/2007	Text	8	
MC002	National Plan ID	1/31/2007	Text	30	
MC003	Insurance Type/Product Code	1/31/2007	Text	2	
MC004	Payer Claim Control Number	1/31/2007	Text	35	
MC005	Line Counter	1/31/2007	Integer	4	
MC005A	Version Number	1/31/2007	Integer	4	
MC006	Insured Group or Policy Number	1/31/2007	Text	30	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC007	Subscriber Unique Identification Number	1/31/2007	Text	9	Y
MC008	Plan Specific Contract Number	1/31/2007	Text	80	Y
MC009	Member Suffix or Sequence Number	1/31/2007	Integer	20	
MC010	Member Social Security Number	1/31/2007	Text	9	
MC011	Individual Relationship Code	1/31/2007	Text	2	
MC012	Member Gender	1/31/2007	Text	1	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC013	Member Date of Birth	1/31/2007	Date	8	
MC014	Member City Name	1/31/2007	Text	30	
MC015	Member State or Province	1/31/2007	Text	2	
MC016	Member ZIP Code	1/31/2007	Text	11	
MC017	Date Service Approved/Accounts Payable Date/Actual Paid Date	1/31/2007	Date	8	
MC018	Admission Date	1/31/2007	Date	8	
MC019	Admission Hour	1/31/2007	Text	4	
MC020	Admission Type	1/31/2007	Integer	1	
MC021	Admission Point of Origin	1/31/2007	Text	1	
MC022	Discharge Hour	1/31/2007	Text	4	
MC023	Discharge Status	1/31/2007	Text	2	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC023 (Cont'd.)	Discharge Status				
MC024	Rendering Provider Number	1/31/2007	Text	30	
MC025	Rendering Provider Tax ID Number	1/31/2007	Text	9	
MC026	National Rendering Provider NPI	1/31/2007	Text	10	
MC027	Rendering Provider Entity Type	1/31/2007	Text	1	
MC028	Rendering Provider First Name	1/31/2007	Text	25	
MC029	Rendering Provider Middle Name	1/31/2007	Text	25	
MC030	Rendering Provider Last Name or	1/31/2007	Text	60	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC031	Rendering Provider Suffix	1/31/2007	Text	10	
MC032	Rendering Provider Specialty	1/31/2007	Text	50	
MC033	Rendering Provider City Name	1/31/2007	Text	30	
MC034	Rendering Provider State or	1/31/2007	Text	2	
MC035	Rendering Provider ZIP Code	1/31/2007	Text	11	
MC036	Type of Bill - Institutional/ Facility Claims, such as those submitted using on UB04 forms	1/31/2007	Integer	2	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC036 (Cont'd.)	Type of Bill -				
MC037	Place of Service Code CMS 1500 Claims	1/31/2007	Text	2	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC037 (Cont'd.)	Site of Service –				
MC038	Claim Status	1/31/2007	Text	2	
MC039	Admitting Diagnosis	1/31/2007	Text	7	
MC040	External Caise of Injury Code	1/31/2007	Text	7	
MC041	Principal Diagnosis	ICD Version Indicator	7/1/2015	Text	9	
MC042	Other Diagnosis – 1	1/31/2007	Text	7	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC043	Other Diagnosis – 2	1/31/2007	Text	7	
MC044	Other Diagnosis – 3	1/31/2007	Text	7	
MC045	Other Diagnosis – 4	1/31/2007	Text	7	
MC046	Other Diagnosis – 5	1/31/2007	Text	7	
MC047	Other Diagnosis – 6	1/31/2007	Text	7	
MC048	Other Diagnosis – 7	1/31/2007	Text	7	
MC049	Other Diagnosis – 8	1/31/2007	Text	7	
MC050	Other Diagnosis – 9	1/31/2007	Text	7	
MC051	Other Diagnosis – 10	1/31/2007	Text	7	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC052	Other Diagnosis – 11	1/31/2007	Text	7	
MC053	Other Diagnosis – 12	1/31/2007	Text	7	
MC054	Revenue Code	1/31/2007	Text	4	
MC055	Procedure Code | Vermont ACO Payment Arrangement Indicator	4/1/2018	Text	7	
MC056	Procedure 1 Modifier – 1	1/31/2007	Text	2	
MC057	Procedure 1 Modifier – 2	1/31/2007	Text	2	
MC058	ICD-10-CM Procedure Code	1/31/2007	Text	4	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC059	Date of Service – From	1/31/2007	Date	8	
MC060	Date of Service – Thru	1/31/2007	Date	8	
MC061	Quantity	1/31/2007	Integer	3	
MC062	Charge Amount	1/31/2007	Decimal	10,2	
MC063	Paid Amount	1/31/2007	Decimal	10,2	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC064	Prepaid Amount	1/31/2007	Decimal	10,2	
MC065	Copay Amount	1/31/2007	Decimal	10,2	
MC066	Coinsurance Amount	1/31/2007	Decimal	10,2	
MC067	Deductible Amount	1/31/2007	Decimal	10,2	
MC068	Medical Record Number	1/31/2007	Text	20	
MC069	Discharge Date	1/31/2007	Date	8	
MC070	Service Provider Country Name	1/31/2007	Text	30	
MC071	DRG	1/31/2007	Text	7	
MC072	DRG Version	1/31/2007	Text	2	
MC073	APC	1/31/2007	Text	4	
MC074	APC Version	1/31/2007	Text	2	
MC075	Drug Code	1/31/2007	Text	11	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
MC076	Billing Provider Number	1/31/2007	Text	30	
MC077	Billing Provider NPI	1/31/2007	Text	10	
MC078	Billing Provider Last Name	1/31/2007	Text	60	
MC101	Subscriber Last Name	1/31/2007	Text	60	
MC102	Subscriber First Name	1/31/2007	Text	35	
MC103	Subscriber Middle Initial	1/31/2007	Text	1	
MC104	Member Last Name	1/31/2007	Text	60	
MC105	Member First Name	1/31/2007	Text	35	
MC106	Member Middle Initial	1/31/2007	Text	1	
MC899	Record Type	1/31/2007	Text	2	

Description/Codes/Sources

Payer submitting payments

CMS National Plan ID

12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
14 Exclusive Provider Organization (EPO)
15 Indemnity Insurance
16 Health Maintenance Organization (HMO) Medicare Advantage
HM Health Maintenance Organization
MA Medicare Part A
MB Medicare Part B
MC Medicaid
OF Other Federal Program (e.g. Black Lung)
SP Medicare Supplemental
TV Title V
VA Veteran Administration Plan

Must apply to the entire claim and be unique within the payer's system.

The line number for this service.
The line counter begins with 1 and is incremented by 1 for each additional
 additional service line of a claim.

The version number of this claim service line.
The version number begins with 0 and is incremented by 1 for each
subsequent version of that service line.

Group or policy number - not the number that uniquely identifies the
subscriber.

Description/Codes/Sources

The subscriber's social security number; used to create
unique member ID. Set as null if unavailable.

The plan assigned contract number.
Set as null if contract number equals subscriber's social
security number.

The unique number of the member within the contract.

The member's social security number; used to create
unique member ID. Set as null if unavailable.

Member's relationship to insured as shown below:
01 Spouse
18 Self
19 Child
20 Employee
21 Unknown
39 Organ donor
40 Cadaver donor
53 Life partner
G8 Other Relationship

M Male
F Female
U Unknown

Description/Codes/Sources

YYYYMMDD

The city name of the member.

As defined by the US Postal Service

ZIP Code of member - may include non-US codes. Do not include dash.

YYYYMMDD

Required for all inpatient claims.
YYYYMMDD

Required for all inpatient claims.
Time is expressed in military time – HHMM

Required for all inpatient claims.
Refer to Appendix A.

Required for all inpatient claims.
Refer to Appendix A.

Hour in military time - HHMM

Required for all inpatient claims.
01 Discharged to home or self care
02 Discharged/transferred to another short term general hospital
      for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF)
04 Discharged/transferred to nursing facility (NF)
05 Discharged/transferred to another type of institution for inpatient
      care or referred for outpatient services to another institution
06 Discharged/transferred to home under care of organized home health
       service organization
07 Left against medical advice or discontinued care
08 Discharged/transferred to home under care of a Home IV provider
09 Admitted as an inpatient to this hospital
20 Expired

Description/Codes/Sources

30 Still patient or expected to return for outpatient services
40 Expired at home
41 Expired in a medical facility
42 Expired, place unknown
43 Discharged/transferred to a Federal Hospital
50 Hospice – home
51 Hospice – medical facility
61 Discharged/transferred within this institution to a hospital -based
     Medicare-approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility including
     distinct parts of a hospital
63 Discharged/transferred to a long term care hospital
64 Discharged/transferred to a nursing facility certified under Medicaid
     but not certified under Medicare

Payer assigned provider number.
This number should be the identifier used by the payer for internal
identification purposes, and does not routinely change. In many cases,
it will be the provider Medicare number.

Federal taxpayer's identification number.

National Provider Identifier (NPI) for the rendering provider or entity.
For the billing provider, see MC077.

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", and these shall be coded as a
person. Insurers and health care processors shall code according to:
1 Person
2 Non-Person Entity

Individual first name.
Set to null if provider is a facility or organization.

Individual middle name or initial.
Set to null if provider is a facility or organization.

Full name of provider organization or last name of individual provider.

Description/Codes/Sources

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 (Jr., Sr., III.), if applicable, rather than the clinician's degree (MD, LCSW).

Rendering provider's taxonomy or payer-assigned speciality code
Dictionary for specialty code values must be supplied during testing.

City name of where the service was rendered. When not available (e.g. ambulance services), report the organization or provider's location city.

As defined by the US Postal Service.

ZIP Code of provider - may include non-US codes. Do not include dash.

Required for institutional claims. Not to be used for professional claims.

Type of Facility - First Digit
1 Hospital
2 Skilled Nursing
3 Home Health
4 Christian Science Hospital
5 Christian Science Extended Care
6 Intermediate Care
7 Clinic
8 Special Facility
Bill Classification - Second Digit if First Digit = 1-6
1 Inpatient (Including Medicare Part A)
2 Inpatient (Medicare Part B Only)
3 Outpatient
4 Other (for hospital referenced diagnostic services or
   home health not under a plan of treatment)
5 Nursing Facility Level I
6 Nursing Facility Level II
7 Intermediate Care - Level III Nursing Facility
8 Swing Beds
Bill Classification - Second Digit if First Digit = 7

Description/Codes/Sources

1 Rural Health
2 Hospital Based or Independent Renal Dialysis Center
3 Free Standing Outpatient Rehabilitation Facility (ORF)

Description/Codes/Sources

5 Comprehensive Outpatient Rehabilitation Facilities (CORFs)
6 Community Mental Health Center
9 Other
Bill Classification - Second Digit if First Digit = 8
1 Hospice (Non Hospital Based)
2 Hospice (Hospital-Based)
3 Ambulatory Surgery Center
4 Free Standing Birthing Center
9 Other

Required for professional claims
Not to be used for institutional claims
11 Office
12 Home
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room - Hospital
24 Ambulatory Surgery Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
35 Boarding Home
41 Ambulance - Land
42 Ambulance - Air or Water
50 Federally Qualified Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic

Description/Codes/Sources

81 Independent Laboratory
99 Other Unlisted Facility

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

Required on all inpatient admission claims and encounters using the
ICD-10-CM. Do not code decimal point

Describes an injury, poisoning or adverse effect
ICD-10-CM. Do not include decimal

ICD diagnosis for the Principal Diagnosis and the ICD Version Indicator
separated by the pipe character. For example, ICD diagnosis code V30.00
(i.e., single liveborn, born in hospital, delivered without mention of
cesarean section) would be reported in the asterisk-delimited file as
V3000|9. Note that the ICD Version Indicator should declare the version
of ICD reported on this service line. The only valid codes for this field are:

9 = ICD-9
0 = ICD-10

Notes: Do not include the decimal point when coding the diagnosis field.

The ICD Version Indicator reported here should pertain to the entire claim
and to all of its ICD diagnosis and procedure codes. It is not to be reported
redundantly with the other diagnosis and procedure codes.

ICD-10-CM. Do not code decimal point

Description/Codes/Sources

ICD-10-CM. Do not code decimal point

ICD-10-CM. Do not code decimal point

ICD-10-CM. Do not code decimal point

ICD-10-CM. Do not code decimal point

ICD-10-CM. Do not code decimal point

ICD-10-CM. Do not code decimal point

ICD-10-CM. Do not code decimal point

ICD-10-CM. Do not code decimal point

ICD-10-CM. Do not code decimal point

Description/Codes/Sources

ICD-10-CM. Do not code decimal point

ICD-10-CM. Do not code decimal point

National Uniform Billing Committee Codes
Code using leading zeros, left justified and four digits.

HCPCS, CPT, or HIPPS code for the service rendered and the ACO Payment Arrangement
Indicator, if applicable.

Only those submitters requested to report participation in a Vermont ACO should use the
following codes for the ACO Payment Arrangement Indicator component of this field:

0 = Not paid under ACO capitation
1 = Paid under ACO capitation

Examples of combined Procedure Code and ACO Payment Arrangement Indicator
separated by pipe character reported in an asterisk-delimited file:

99211|1 = Procedure Code and paid under ACO capitation⬚
|0 = No Procedure Code and Not paid under ACO capitation⬚

Notes: There are no spaces between the Procedure Code and the pipe character and
between the pipe character and the ACO Payment Arrangement Indicator.

This includes the CPT codes of the American Medical Association.

Procedure modifier required when a modifier clarifies or improves the
reporting accuracy of the associated procedure code.
When the insurer utilizes a local code system for modifiers, a reference
table shall be submitted.

Procedure modifier required when a modifier clarifies or improves the
reporting accuracy of the associated procedure code.
When the insurer utilizes a local code system for modifiers, a reference
table shall be submitted.

Primary ICD-10-CM code for this line of service. Do not code decimal point.

Description/Codes/Sources

First date of service for this service line
YYYYMMDD

Last date of service for this service line
YYYYMMDD

Count of services performed, which shall be set equal to one on all
observation bed service lines and should be set equal to zero on all other
room and board service lines, regardless of the length of stay.

Do not code decimal point.

Includes any withhold amounts. Do not code decimal point
This element includes all payments made by the insurer except capitation.

Description/Codes/Sources

For capitated services - the fee for service equivalent amount.
Do not code decimal point.

The preset, fixed dollar amount for which the individual is responsible.
Do not code decimal point

The dollar amount an individual is responsible for – not the percentage.
Do not code decimal point

The dollar amount of the deductible.
Do not code decimal point.

Number assigned by hospital.

Date patient discharged. Required for all inpatient claims.
YYYYMMDD

Code US for United States.

Insurers and health care claims processors shall code using the CMS
methodology when available. Precedence shall be given to DRGs
transmitted from the hospital provider. When the CMS methodology for
DRGs is not available, but the All Payer DRG system is used, the insurer
shall format the DRG and the complexity level within the same field with an
"A" prefix, and with a hyphen separating the DRG and the complexity level
(e.g. AXXX-XX)

Version number of the grouper used.

Insurers and health care claims processors shall code using the CMS
methodology when available. Precedence shall be given to APCs
transmitted from the health care provider.

Version number of the grouper used.

Insurers and health care claims processors shall code according to NDC .
code.

Description/Codes/Sources

Payer assigned provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change.

National Provider Identifier (NPI) mandated for use under HIPAA.

Full name of billing organization or last name of individual billing or Organization Name.

The subscriber last name.

The subscriber first name.

The subscriber middle initial.

The member last name.

The member first name.

The member middle initial.

Value = MC

Data Element #	UB-04 Data Element Name	CMS 1500 #	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC001	N/A	N/A	N/A
MC002	N/A	N/A	835/1000A/N1/XV/04
MC003	N/A	N/A	835/2100/CLP/ /06
MC004	N/A	N/A	835/2100/CLP/ /07
MC005	N/A	N/A	837/2400/LX/ /01
MC005A	N/A	N/A	N/A
MC006	62 (A-C)	11C	837/2000B/SBR/ /03
MC007	N/A	N/A	835/2100/NM1/FI/09
MC008	60 (A-C)	1a	835/2100/NM1/MI/09
MC009	N/A	N/A	N/A
MC010	N/A	N/A	835/2100/NM1/34/09
MC011	59 (A-C)	6	837/2000B/SBR/ /02, 837/2000C/PAT/ /01
MC012	11	3	837/2010BA/DMG/ /03, 837/2010CA/DMG/ /03
MC013	10	3	837/2010BA/DMG/D8/02, 837/2010CA/DMG/D8/02
MC014	09 (b)	5	837/2010BA/N4/ /01, 837/2010CA/N4/ /01,
MC015	09 (c)	5	837/2010BA/N4/ /02 837/2010CA/N4/ /02
MC016	09 (d)	5	837/2010BA/N4/ /03, 837/2010CA/N4/ /03
MC017	N/A	N/A	835/Header Financial Information/BPR/ /16
MC018	12	18	837/2300/DTP/435/DT/03
MC019	13	N/A	Institutional 837/2300/DTP/435/03
MC020	14	N/A	Institutional 837/2300/CL1/ /01
MC021	15	N/A	Institutional 837/2300/CL1/ /02
MC022	16	N/A	Institutional 837/2300/DTP/096/03
MC023	17	N/A	Institutional 837/2300/CL1/ /03

Data Element #	UB-04 Data Element Name	CMS 1500 #	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC024	57	24J	835/2100/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09
MC025	835/2100/NM1/FI/09	25	835/2100/NM1/FI/09
MC026	835/2100/NM1/XX/09	N/A	835/2100/NM1/XX/09
MC027	835/2100/NM1/82/02	N/A	835/2100/NM1/82/02

Data Element #	UB-04 Data Element Name	CMS 1500 #	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC028	835/2100/NM1/82/04	33	835/2100/NM1/82/04
MC029	835/2100/NM1/82/05	33	835/2100/NM1/82/05
MC030	835/2100/NM1/82/03	33	835/2100/NM1/82/03
MC031	N/A	31	Professional 837/2420A/NM1/82/07, 837/2310B/NM1/82/07, 835/2100/NM1/82/03
MC032	N/A	24J Qualifier ZZ	Institutional 837/2000A/PRV/PXC/03 Professional 837/2310B/PRV/PXC/03
MC033	1	32	Institutional 837/2010AA/N4/ /01 Professional 837/2420C/N4/ /01, 837/2310C/N4/ /01
MC034	1	32	Institutional 837/2010AA/N4/ /02 Professional 837/2420C/N4//02, 837/2310C/N4/ /02
MC035	1	32	Institutional 837/2010AA/N4/ /03 Professional 837/e2420C/N4/ /03, 837/2310C/N4/ /03
MC036	4	N/A	Institutional 837/2300/CLM/ /05-1
MC037	N/A	24B	Professional 837/2300/CLM/ /05-1
MC038	N/A	N/A	835/2100/CLP/ /02
MC039	69	N/A	Institutional 837/2300/HI/BJ/01-2, 837/2300/HI/ABJ/01-2

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Data Element #	UB-04 Data Element Name	CMS 1500 #	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC040	72a	N/A	Institutional 837/2300/HI/BN/01-2, 837/2300/HI/ABN/01-2
MC041	67/66	21.1	Principal Diagnosis: 837/2300/HI/BK/01-2, 837/2300/HI/ABK/01-2
MC042	67A	CMS 1500 Version 08/05 21.2, CMS 1500 Version 02/12 21.B	Institutional 837/2300/HI/BF/01-2, 837/2300/HI/ABF/01-2 Professional 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2
MC043	67B	CMS 1500 Version 08/05 21.3, CMS 1500 Version 02/12 21.C	Institutional 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2 Professional 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2
MC044	67C	CMS 1500 Version 08/05, 21.4 CMS D500 Version 02/12 21.D	Institutional 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2 Professional 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2

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Data Element #	UB-04 Data Element Name	CMS 1500 #	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC045	67D	CMS 1500 Version 02/12 21.E	Institutional 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2 Professional 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2
MC046	67E	CMS 1500 Version 02/12 21.F	Institutional 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2 Professional 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2
MC047	67F	CMS 1500 Version 02/12 21.G	Institutional 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2 Professional 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2
MC048	67G	CMS 1500 Version 02/12 21.H	Institutional 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2 Professional 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2
MC049	67H	CMS 1500 Version 02/12 21.I	Institutional 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2 Professional 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2
MC050	67I	CMS 1500 Version 02/12 21.J	Institutional 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2 Professional 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2

Data Element #	UB-04 Data Element Name	CMS 1500 #	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC051	67J	CMS 1500 Version 02/12 21.K	Institutional 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2 Professional 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2
MC052	67K	CMS 1500 Version 02/12 21.L	Institutional 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2 Professional 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2
MC053	67L	N/A	Institutional 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2
MC054	42	N/A	835/2110/SVC/NU/01-2 835/2110/SVC/ /04
MC055	44	24.D	835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2
MC056	44	24.D	835/2110/SVC/HC/01-3
MC057	44	24.D	835/2110/SVC/HC/01-4
MC058	74	N/A	Institutional 837/2300/HI/BR/01-2 837/2300/HI/BBR/01-2
MC059	45	24 A	835/2110/DTM/472/02, 835/2110/DTM/150/02

Data Element	UB-04	CMS 1500	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/
#	Data Element Name	#	Reference Designator
MC060	N/A	24 A	835/2110/DTM/472/02, 835/2110/DTM/151/02
MC061	46	24 G	835/2110/SVC/ /05
MC062	46	24 G	835/2110/SVC/ /05
MC063	N/A	N/A	835/2110/SVC/ /03
MC064	N/A	N/A	N/A
MC065	N/A	N/A	835/2110/CAS/PR/3-03
MC066	N/A	N/A	835/2110/CAS/PR/2-03
MC067	N/A	N/A	835/2110/CAS/PR/1-03
MC068	3B	N/A	837/2300/REF/EA/02
MC069	6	18	Institutional 837/2300/DTP/RD8/04 Professional 837/2300/DTP/D8/03
MC070	N/A	N/A	837/2310C/N4/07
MC071	N/A	N/A	Institutional 837/2300/HI/DR/01-2
MC072	N/A	N/A	N/A
MC073	N/A	N/A	835/2110/REF/APC/02
MC074	N/A	N/A	N/A
MC075	43	24	837/2410/LIN/N4/03
MC076	57	33b	837/2010BB/REF/G2/02
MC077	56	33a	837/2010AA/NM1/XX/09
MC078	1	33	837/2010AA/NM1/ /03
MC101	58(A-C)	4	837/2010BA/NM1/ /03
MC102	58(A-C)	4	837/2010BA/NM1/ /04
MC103	58(A-C)	4	837/2010BA/NM1/ /05
MC104	8a	2	837/2010CA/NM1/ /03, 837/2010BA/NM1/ /03
MC105	8a	2	837/2010CA/NM1/ /04, 837/2010BA/NM1/ /04
MC106	8a	2	837/2010CA/NM1/ /05, 837/2010BA/NM1/ /05
MC899	N/A	N/A	N/A

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
PC001	Submitter Code	1/31/2007	Text	8	
PC002	National Plan ID	1/31/2007	Text	30	
PC003	Insurance Type/Product Code	1/31/2007	Text	2	
PC004	Payer Claim Control Number	1/31/2007	Text	35	
PC005	Line Counter	1/31/2007	Integer	4	
PC006	Insured Group Number	1/31/2007	Text	50	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
PC007	Subscriber Unique Identification Number	1/31/2007	Text	9	Y
PC008	Plan Specific Contract Number	1/31/2007	Text	80	Y
PC009	Member Suffix or Sequence Number	1/31/2007	Integer	20	
PC010	Member Identification Code	1/31/2007	Text	9	Y
PC011	Individual Relationship Code	1/31/2007	Text	2	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
PC012	Member Gender	1/31/2007	Integer	1	
PC013	Member Date of Birth	1/31/2007	Date	8	
PC014	Member City Name of Residence	1/31/2007	Text	30	
PC015	Member State or Province	1/31/2007	Text	2	
PC016	Member ZIP Code	1/31/2007	Text	9	
PC017	Date Service Approved (AP Date)	1/31/2007	Date	8	
PC018	Pharmacy Number	1/31/2007	Text	30	
PC019	Pharmacy Tax ID Number	1/31/2007	Text	10	
PC020	Pharmacy Name	1/31/2007	Text	30	
PC021	National Pharmacy NPI	1/31/2007	Text	10	
PC022	Pharmacy Location City	1/31/2007	Text	30	
PC023	Pharmacy Location State	1/31/2007	Text	2	
PC024	Pharmacy ZIP Code	1/31/2007	Text	10	
PC024A	Pharmacy Country Name	1/31/2007	Text	30	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
PC025	Claim Status	1/31/2007	Text	2	
PC026	National Drug Code	1/31/2007	Text	11	
PC027	Drug Name	1/31/2007	Text	80	
PC028	New Prescription	1/31/2007	Text	2	
PC029	Generic Drug Indicator	1/31/2007	Text	1	
PC030	Dispense as Written Code	1/31/2007	Integer	1	
PC031	Compound Drug Indicator	1/31/2007	Text	1	
PC032	Date Prescription Filled	1/31/2007	Date	8	
PC033	Quantity Dispensed	1/31/2007	Integer	5	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
PC034	Days Supply	1/31/2007	Integer	3	

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
PC035	Charge Amount	1/31/2007	Decimal	10,2	
PC036	Paid Amount	1/31/2007	Decimal	10,2	
PC037	Ingredient Cost/List Price	1/31/2007	Decimal	10,2	
PC038	Postage Amount Claimed	1/31/2007	Decimal	10,2	
PC039	Dispensing Fee	1/31/2007	Decimal	10,2	
PC040	Copay Amount	1/31/2007	Decimal	10,2	
PC041	Coinsurance Amount	1/31/2007	Decimal	10,2	
PC042	Deductible Amount	1/31/2007	Decimal	10,2	
PC043	Placeholder	1/31/2017	N/A	N/A	
PC044	Prescribing Physician First Name	1/31/2007	Text	25	
PC045	Prescribing Physician Middle Name	1/31/2007	Text	25	
PC046	Prescribing Physician Last Name	1/31/2007	Text	60	
PC047	Prescribing Physician Number	1/31/2007	Text	9	
PC101	Subscriber Last Name	1/31/2007	Text	60	Y
PC102	Subscriber First Name	1/31/2007	Text	35	Y
PC103	Subscriber Middle Initial	1/31/2007	Text	1	Y
PC104	Member Last Name	1/31/2007	Text	60	Y
PC105	Member First Name	1/31/2007	Text	35	Y

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Hashed?
PC106	Member Middle Initial	1/31/2007	Text	1	Y
PC899	Record Type	1/31/2007	Text	2	

Description/Codes/Sources

Payer submitting payments
BISHCA Submitter Code

CMS National Plan ID

12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
14 Exclusive Provider Organization (EPO)
15 Indemnity Insurance
16 Health Maintenance Organization (HMO) Medicare Advantage
HM Health Maintenance Organization
MD Medicare Part D
MC Medicaid
OF Other Federal Program (e.g. Black Lung)
TV Title V

Must apply to the entire claim and be unique within the payer's system.

Line number for this service.
The line counter begins with 1 and is incremented by 1 for each
additional service line of a claim.

The group or policy number – not the number that uniquely identifies the
subscriber.

Description/Codes/Sources

The subscriber's social security number; used to create
unique member ID. Set as null if unavailable.

The plan assigned contract number.
Set as null if contract number equals subscriber's social security number.

The unique number that identifies the member within the contract.

The member's social security number; used to create
unique member ID. Set as null if unavailable.

Member's relationship to insured
01 Spouse
18 Self
19 Child
20 Employee
21 Unknown
39 Organ donor
40 Cadaver donor
53 Life partner
G8 Other relationship

Description/Codes/Sources

1 Male
2 Female
3 Unknown

YYYYMMDD

The city name of member.

As defined by the US Postal Service

ZIP Code of member – may include non-US codes. Do not include dash.

YYYYMMDD
This date is generally the same date as the paid date or the pharmacy
benefits manager's billing date.

The payer assigned pharmacy number.
This number should be the identifier used by the payer for
internal identification purposes, and does not routinely
change. An AHFS number is acceptable.

Insurers and health care claims processors shall provide the pharmacy
chain's federal tax identification number, if the individual retail
pharmacy's tax ID# is not available.

The name of pharmacy

National Provider Identifier (NPI)

The city name of pharmacy, preferably pharmacy location.

As defined by the US Postal Service

ZIP Code of pharmacy – may include non-US codes. Do not include dash.

Code US for United States

Description/Codes/Sources

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

NDC Code

Text name of drug

00 New prescription
01-99 Number of refill

N No, branded drug
Y Yes, generic drug

0 Not dispensed as written
1 Physician dispense as written
2 Member dispense as written
3 Pharmacy dispense as written
4 No generic available
5 Brand 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

N Non-compound drug
Y Compound drug
U Non-specified drug compound

YYYYMMDD

Number of metric units of medication dispensed

Description/Codes/Sources

Estimated number of days the prescription will last

Description/Codes/Sources

Includes all health plan payments and excludes all member payments.

Cost of the drug dispensed. Do not code decimal point

The preset, fixed dollar amount for which the individual is responsible.

The dollar amount an individual is responsible for – not the percentage.

N/A

Physician first name Required if PC047 is not filled.

Physician middle name or initial Required if PC047 is not filled.

Physician last name Required if PC047 is not filled.

DEA or NPI number for prescribing physician.

The subscriber last name.

The subscriber first name.

The subscriber middle initial.

The member last name.

The member first name.

Description/Codes/Sources

The member middle initial.

Value = PC

Data Element #	Data Element Name	National Council for Prescription Drug Programs Field #	NCPDP mapping
PC001	Payer	N/A	N/A
PC002	Plan ID	N/A	N/A
PC003	Insurance Type/Product Code	N/A	N/A
PC004	Payer Claim Control Number	N/A	993-A7
PC005	Line Counter	N/A	N/A
PC006	Insured Group Number	301-C1	301-C1
PC007	Encrypted Subscriber Unique Identification Number	302-C2	N/A
PC008	Plan Specific Contract Number	N/A	302-C2
PC009	Member Suffix or Sequence Number	N/A	N/A
PC010	Member Identification Code	302-CY	N/A
PC011	Individual Relationship Code	306-C6	N/A
PC012	Member Gender	305-C5	305-C5
PC013	Member Date of Birth	304-C4	304-C4
PC014	Member City Name of Residence	323-CN	323-CN
PC015	Member State or Province	324-CO	324-CO
PC016	Member ZIP Code	325-CP	325-CP
PC017	Date Service Approved (AP Date)	N/A	216
PC018	Pharmacy Number	202-B2	201-B1
PC019	Pharmacy Tax ID Number	N/A	N/A
PC020	Pharmacy Name	833-5P	833-5P
PC021	National Pharmacy ID Number	N/A	201-B1
PC022	Pharmacy Location City	831-5N	728
PC023	Pharmacy Location State	832-6F	729
PC024	Pharmacy ZIP Code	835-5R	730
PC024A	Pharmacy Country Name	N/A	N/A
PC025	Claim Status	N/A	N/A
PC026	Drug Code	407-D7	407-D7
PC027	Drug Name	516-FG	516-FG
PC028	New Prescription or Refill	403-D3	403-D3
PC029	Generic Drug Indicator	N/A	425-DP
PC030	Dispense as Written Code	408-D8	408-D8
PC031	Compound Drug Indicator	406-D6	N/A

Data Element #	Data Element Name	National Council for Prescription Drug Programs Field #	NCPDP mapping
PC032	Date Prescription Filled	401-D1	401-D1
PC033	Quantity Dispensed	442-E7	442-E7
PC034	Days Supply	405-D5	405-D5
PC035	Charge Amount	804-5B	430-DU
PC036	Paid Amount	509-F9	509-F9
PC037	Ingredient Cost/List Price	506-F6	506-F6
PC038	Postage Amount Claimed	428-DS	N/A
PC039	Dispensing Fee	507-F7	507-F7
PC040	Co-pay Amount	518-FI	518-FI
PC041	Coinsurance Amount	518-FI	572-4U
PC042	Deductible Amount	505-F5	517-FH
PC044	Prescribing Physician First Name	N/A	N/A
PC045	Prescribing Physician Middle Name	N/A	N/A
PC046	Prescribing Physician Last Name	N/A	427-DR
PC047	Prescribing Physician Number	N/A	421-DL
PC101	Encrypted Subscriber Last Name	N/A	313-CD
PC102	Encrypted Subscriber First Name	N/A	312-CC
PC103	Encrypted Subscriber Middle Initial	N/A	N/A
PC104	Encrypted Member Last Name	N/A	311-CB
PC105	Encrypted Member First Name	N/A	310-CA
PC106	Encrypted Member Middle Initial	N/A	N/A
PC899	Record Type	N/A	N/A