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	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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COL	FIELD	LENGTH	NOTES
14	BENEFICIARY IDENTIFICATION CODE (12) **(bic)**	2	Relationship between individual and a primary Social Security Administration Beneficiary. (Refer to appendix table BIC)
16	BENEFICIARY RESIDENCE SSA STANDARD STATE CODE (14) **(state_cd)**	2	State of Beneficiary's residence, SSA Standard Code. (Refer to appendix table STATE_CD)
18	CLAIM FROM DATE (15) **(from_dtm, from_dtd, from_dty)**	8	For Institutional or CWFB Claim, first day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
26	CLAIM THROUGH DATE (16) **(thru_dtm, thru_dtd, thru_dty)**	8	Last day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
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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COL	FIELD	LENGTH	NOTES
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) **(asgmntcd)**	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 submitted charges on the claim (the sum of line item submitted charges).

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COL	FIELD	LENGTH	NOTES
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) **(dvrsncd1-dvrsncd12)**	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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COL	FIELD	LENGTH	NOTES
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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COL	FIELD	LENGTH	NOTES
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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COL	FIELD	LENGTH	NOTES
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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COL	FIELD	LENGTH	NOTES
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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COL	FIELD	LENGTH	NOTES
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) **(hrsltnum)**	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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