Indiana All Payer Claims Database (IN APCD)

Data Submission Guide (Version 2.0)

for Use with the APCD-CDL™ (Version 2.1)

Updated: December 2025

This file is a product of Onpoint Health Data and has been created for use only by the Indiana Department of Insurance and data submitters participating in the Indiana APCD.

For assistance or for technical questions related to specifications, mapping, and implementation, please contact Onpoint's support team for the Indiana APCD (in-support@onpointhealthdata.org | 207-623-2555).

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#	File Type	Col. #	Field ID	Element Common Name	Description	Effective DSG Version
1	All	N/A	N/A	N/A	"APCD-CDL Guidance" column added to layout specifications tabs to cite formal instructions from the APCD-CDL. (Please review the "Notes on IN-Specific Guidance to Submitters" to understand any supplementary instructions from IDOI and Onpoint for reporting specific fields.)	2.0
2	File Guidelines	N/A	Rule 9	ASCII Characters	Guidance added regarding the ASCII characters that are acceptable for reporting	2.0
3	File Guidelines	N/A	Rule 10	Aggregation Methodology	Guidance added regarding the reporting of negative values for medical and pharmacy claims when using the aggregation consolidation methodology	2.0
4	Eligibility	2	CDLME002	Placeholder	Field name revised from "Payer Code" to clarify that this field is not collected for the IN APCD	2.0
5	Eligibility	3	CDLME003	Placeholder	Field name revised from "Plan ID" to clarify that this field is not collected for the IN APCD	2.0
6	Eligibility	4	CDLME004	Member Insurance / Product Category Code	Specifications updated to note that the reporting of code '19' (Prescription Drugs (Commercial Coverage)) requires pre-approval from IDOI	2.0
7	Eligibility	5	CDLME005	Eligibility Year	Field name revised from "Start Year of Submission" for clarity	2.0
8	Eligibility	6	CDLME006	Eligibility Month	Field name revised from "Start Month of Submission" for clarity	2.0
9	Eligibility	79	CDLMEXXX	Placeholder	Field name revised from "Unassigned" for clarity; description updated to indicate that submitters should report as null.	2.0
11	Medical	2	CDLMC002	Placeholder	Field name revised from "Payer Code" to clarify that this field is not collected for the IN APCD	2.0
12	Medical	3	CDLMC003	Placeholder	Field name revised from "Plan ID" to clarify that this field is not collected for the IN APCD	2.0
13	Medical	17	CDLMC017	Individual Relationship Code	Valid relationship codes included for reporting	2.0
14	Medical	164	CDLMCXXX	Placeholder	Field name revised from "Unassigned" for clarity; description updated to indicate that submitters should report as null.	2.0
16	Pharmacy	2	CDLPC002	Placeholder	Field name revised from "Payer Code" to clarify that this field is not collected for the IN APCD	2.0
17	Pharmacy	3	CDLPC003	Placeholder	Field name revised from "Plan ID" to clarify that this field is not collected for the IN APCD	2.0
18	Pharmacy	4	CDLPC004	Member Insurance / Product Category Code	Specifications updated to note that the reporting of code '19' (Prescription Drugs (Commercial Coverage)) requires pre-approval from IDOI	2.0
19	Pharmacy	17	CDLPC017	Individual Relationship Code	Valid relationship codes included for reporting	2.0
20	Pharmacy	25	CDLPC025	National Drug Code (NDC)	Field name revised from "Drug Code" to clarify reporting requirements	2.0
21	Pharmacy	30	CDLPC030	Drug Name	Field name revised from "Compound Drug Name or Compound Drug Ingredient List" to clarify reporting requirements	2.0
22	Pharmacy	72	CDLPCXXX	Placeholder	Field name revised from "Unassigned" for clarity; description updated to indicate that submitters should report as null.	2.0
23	Provider	2	CDLPV002	Placeholder	Field name revised from "Payer Code" to clarify that this field is not collected for the IN APCD	2.0
24	Provider	3	CDLVC003	Placeholder	Field name revised from "Plan ID" to clarify that this field is not collected for the IN APCD	2.0
25	Provider	29	CDLPVXXX	Placeholder	Field name revised from "Unassigned" for clarity; description updated to indicate that submitters should report as null.	2.0
26	Commissions & Brokerage	N/A	N/A	N/A	New commissions and brokerage layout has been added as a new tab.	2.0
27	N/A	N/A	N/A	N/A	Two new columns (Type and Max. Length) were added to this document within the Header & Trailer", "Eligibility", "Medical Claims", "Pharmacy Claims", & "Provider" tabs.	2.0
28	Header & Trailer	5	CDLHD005, CDLTR005	File Type	The following notes were added: Since the Indiana APCD currently does not collect dental claims, reporting the value of 'DC' is not valid. Please use CB for Commissions & Brokerage files.	2.0
29	Eligibility	10	CDLME010	Subscriber Social Security Number	Revision to field length: The value reported for this field should include only the last four digits of the subscriber's Social Security number.	2.0
30	Eligibility	16	CDLME016	Member Social Security Number	Revision to field length: The value reported for this field should include only the last four digits of the member's Social Security number. Revision to X12 reference: 271/2100C/REF/SY/02, 271/2100D/REF/SY/02	2.0
31	Eligibility	76	CDLME076	ACO Identifier	Use this field to report the ACO ID (aco_id) for the applicable ACO using the IDs maintained by CMS. To access the proper ID, please visit the following link and use its "Basic Filtering" option to select the following sequence: aco_service_area > Contains > IN Link: https://data.cms.gov/medicare-shared-savings-program/accountable-care-organizations/data	2.0
32	Eligibility	77	CDLME077	ACO Name	Use this field to report the ACO Name (aco_name) for the ACO identified above in CDLME076 (ACO Identifier) using the names maintained by CMS. To access the proper name, please visit the following link and use its "Basic Filtering" option to select the following sequence: aco_service_area > Contains > IN Link: https://data.cms.gov/medicare-shared-savings-program/accountable-care-organizations/data	2.0

33	Medical Claims	11	CDLMC011	Subscriber Social Security Number	Revision to field length: The value reported for this field should include only the last four digits of the subscriber's Social Security number.	2.0
34	Medical Claims	16	CDLMC016	Member Social Security Number	Revision to field length: The value reported for this field should include only the last four digits of the member's Social Security number.	2.0
35	Medical Claims	121	CDLMC121	Service Units / Quantity	Use this field to report the total units of measure for the individual type of service being performed, including those for observation stays and room and board service lines. The unit of measure should be based on the relevant reporting code (e.g., CPT, revenue, HCPCS). For example: • Anesthesiology = Minutes • Ambulance = Miles • Room and board = Days Include the decimal. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	2.0
36	Medical Claims	122 - 131	CDLMC122 - CDLMC131		If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	2.0
37	Pharmacy Claims	11	CDLPC011	Subscriber Social Security Number	Revision to field length: The value reported for this field should include only the last four digits of the subscriber's Social Security number.	2.0
38	Pharmacy Claims	16	CDLPC016	Member Social Security Number	Revision to field length: The value reported for this field should include only the last four digits of the subscriber's Social Security number.	2.0
39	Pharmacy Claims	32	CDLPC032	Quantity Dispensed	Include the decimal, with 2 digits trailing the decimal. For example, a quantity of 375.143 should be reported as '375.14.' Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -123.45).	2.0
40	Pharmacy Claims	33	CDLPC033	Days' Supply	Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	2.0
41	Pharmacy Claims	36 - 48	CDLPC036 - CDLPC048		If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	2.0

File Guidelines

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Basic Rules

1	**Header and trailer records.** Each submission regardless of type — eligibility, medical claims, pharmacy claims, and provider — must begin with a header record and end with a trailer record. Your header record must designate the first month o the reporting period using field CDLHD006 (Period Beginning Date) and the last month of the reporting period using field CDLHD007 (Period Ending Date) with both fields using a format of YYYYMM.
2	**No punctuation.** Punctuation should not be included in the reporting of any names, including the names of drugs. For example, a last name of O'Rourke should be reported as 'OROURKE'.
3	**No decimal points unless otherwise specified.** Decimal points should not be included in the reporting of any field unless otherwise specified. For example, a dollar amount of $120.56 should be reported as '12056'. Note that any field with a designated type of "Decimal" or "dec" includes a length notation that includes a comma indicating both the total number of allowable digits (to the left of the comma) and the number of digits that should be reported to the right of the decimal (whether the decimal point itself is implied (as in most situations) or reported (when specified)). For example, a decimal notation of 5,4 indicates that the expected number of total digits to be reported is five, with four digits expected to the right of an implied or reported decimal point as specified.
4	**Date formats.** Dates, unless otherwise specified, should be reported using the eight-digit format of YYYYMMDD. For example, December 18, 2022, should be reported as '20221218'. (The format of reported years should always be YYYY even when indicated as 'CCYY' in CDL specifications.)
5	**Pipe delimiters.** All fields should be separated by a pipe delimiter.
6	**Reporting placeholder fields as null.** Please note that all fields designated as placeholders in the following file layouts should be reported as truly null without data between the standard pipe delimiters (i.e., '||'); please do not report an actual value of the word 'NULL'.
7	**Reporting other fields as null.** If your organization lacks the data to correctly populate a field, please report that field as null (i.e., without data between the standard pipe delimiters). Only actual, valid data should be reported.
8	**Data should be reported whenever available.** Please note that the thresholds included in this guide are made available to inform data submitters on the data quality completeness check to be performed on the data. They are not to be used to determine whether a data element is required for reporting. All data elements are required for reporting whenever available.
9	**ASCII characters.** Only ASCII character codes 0-127 are accepted for reporting. Extended ASCII characters (character codes 128-255) are not accepted.
10	**Reporting reversals/adjustments under the aggregation methodology.** When sending reversals and/or adjustments using the aggregation consolidation methodology, report all quantifiable fields (e.g., dollar fields, quantity, days' supply) related to the reversal/adjustment. Note that the reporting of negative values is acceptable; in such cases, the negative sign must be reported on the leftmost side of the value (e.g., -12345).

File Requirements

File Type	Required Frequency	Specific Deadline	Notes
All	Historical data	It is recommended that historical files be submitted as annual files.	
Eligibility	Monthly	Prior to the last day of the month following the reporting period (e.g., December eligibility reported by January 31).	• One record must be submitted for each member who had coverage for any duration at any point during the reporting period identified in the header record. • Submissions must cover full months of data; partial months must not be reported.
Medical Claims	Monthly	Prior to the last day of the month following the reporting period.	• One record must be submitted for each service adjudicated during the period reported in the header record. • Submissions must cover full months of data; partial months must not be reported.
Pharmacy Claims	Monthly	Prior to the last day of the month following the reporting period.	• One record must be submitted for each service adjudicated during the period reported in the header record. • Submissions must cover full months of data; partial months must not be reported.
Provider	Monthly	Prior to the last day of the month following the reporting period.	• One record must be submitted for each provider reported in the eligibility, medical claims, and pharmacy claims files. • Submissions must cover full months of data; partial months must not be reported.

Header & Trailer

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Header Record

Col. #	Field ID	Field Name	Type	Max. Length	APCD-CDL Guidance	Notes on IN-Specific Guidance to Submitters	Threshold	Condition (Denominator)
1	CDLHD001	Record Type	Text	2	HD.		100%	All
2	CDLHD002	Data Submitter Code	Text	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For the Indiana APCD, valid prefixes include: INC = Commercial carrier ING = Governmental agency INT = Third-party administrator / pharmacy benefits manager Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	All
3	CDLHD003	Payer Code	Text	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	Report as null	0%	All
4	CDLHD004	Data Submitter Name	Text	75	Name of data submitter.		100%	All
5	CDLHD005	File Type	Text	2	ME = Member Eligibility; MC = Medical Claims; PC = Pharmacy Claims; DC= Dental Claims; PV = Provider File.	Since the Indiana APCD currently does not collect dental claims, reporting the value of 'DC' is not valid. Please use CB for Commissions & Brokerage files.	100%	All
6	CDLHD006	Period Beginning Date	Date	6	CCYYMM. Beginning of period covered for Eligibility. Beginning of paid/adjudicated period for Claims. Beginning of period for Provider file updates.		100%	All
7	CDLHD007	Period Ending Date	Date	6	CCYYMM. End of period covered for Eligibility. End of paid/adjudicated period for Claims. End of period for Provider file updates.		100%	All
8	CDLHD008	Test File Flag	Text	1	T = File submitted is a test file P = File submitted is a production file.		100%	All
9	CDLHD009	Comments	Text	50	Comments.		0%	All

Trailer Record

Col. #	Field ID	Field Name	Type	Max. Length	APCD-CDL Guidance	Notes on IN-Specific Guidance to Submitters	Threshold	Condition (Denominator)
1	CDLTR001	Record Type	Text	2	TR.		100%	All
2	CDLTR002	Data Submitter Code	Text	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For the Indiana APCD, valid prefixes include: INC = Commercial carrier ING = Governmental agency INT = Third-party administrator Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	All
3	CDLTR003	Payer Code	Text	8	APCD-assigned identifier of insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	Report as null	0%	All
4	CDLTR004	Data Submitter Name	Text	75	Name of data submitter.		100%	All
5	CDLTR005	File Type	Text	2	ME = Member Eligibility; MC = Medical Claims; PC = Pharmacy Claims; DC= Dental Claims; PV = Provider File.	Since the Indiana APCD currently does not collect dental claims, reporting the value of 'DC' is not valid. Please use CB for Commissions & Brokerage files.	100%	All
6	CDLTR006	Extraction Date	Date	8	CCYYMMDD; Date file was created.		100%	All
7	CDLTR007	Control Total of Paid Amount	Integer	12	Medical (MC) Pharmacy (PC) and Dental (DC) Claims files only. Provide total paid dollars submitted in the file. Control total for each file (CDLMC125, CDLPC037, CDLDC060). Eligibility and provider file blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).		100%	Medical, Pharmacy
8	CDLTR008	Record Count	Integer	10	Total number of records submitted in the file, excluding header and trailer records.		100%	All

Eligibility

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Col. #	Field ID	Field Name	Type	Max. Length	APCD-CDL Guidance	Notes on IN-Specific Guidance to Submitters	Threshold	Condition (Denominator)
1	CDLME001	Data Submitter Code	Text	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code used in the Payer Code field.	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For the Indiana APCD, valid prefixes include: INC = Commercial carrier ING = Governmental agency INT = Third-party administrator / pharmacy benefits manager Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	All
2	CDLME002	Placeholder	Text	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi- tiered to support different platforms).	Report as null.	0%	All
3	CDLME003	Placeholder	Text	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER)	Report as null.	0%	All
4	CDLME004	Member Insurance / Product Category Code	Text	2	See Appendix G-1: Insurance/Product Category for codes. Use the most granular choice available.	The only valid product codes for reporting are: 17 = Dental 19 = Prescription Drugs (Commercial Coverage) - **Requires pre-approval from IDOI** AB = Medicare Part A & B (Medicare FFS only) DM = Dental Maintenance Organization E = Medicare - Point of Service (POS) EP = Exclusive Provider Organization FH = Federal Employees Health Benefits Program (HMO) FP = Federal Employees Health Benefits Program (PPO) HM = Health Maintenance Organization (HMO) HN = Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C IN = Indemnity MA = Medicare Part A (Medicare FFS Only) MB = Medicare Part B (Medicare FFS Only) MC = Medicaid MD = Medicare Part D MO = Medicare Advantage PPO PR = Preferred Provider Organization (PPO) PS = Point of Service (POS) SP = Medicare Supplemental Policy	100%	All
5	CDLME005	Eligibility Year	Integer	4	The year for which eligibility is reported in this submission file. CCYY.	Use this field to report the year of eligibility using a 4-digit format of YYYY (e.g., January 2022, would be coded as '2022').	100%	All
6	CDLME006	Eligibility Month	Text	2	The month for which eligibility is reported in this submission file expressed numerical from 01 to 12.	Use this field to report the month of eligibility using a 2-digit format of MM (e.g., January would be coded as '01').	100%	All
7	CDLME007	Insured Group or Policy Number	Text	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. ME006 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	The value reported for this field should be reported consistently in the "Insured Group or Policy Number" field across all file types: eligibility (CDLME007), medical claims (CDLMC009), and pharmacy claims (CDLPC009) data. If a policy is sold to an individual as a non-group policy, then both the Insured Group or Policy Number (CDLME007) and Group Name (CDLME045) should be reported with a value of 'IND'. Medicaid and Medicare plans follow this same principle and should be reported as 'IND'.	99%	All
8	CDLME008	Coverage Level Code	Text	3	Benefit coverage level selected: CHD = Children Only; DEP = Dependents Only; ECH =Subscriber and Children/dependents; EMP = Subscriber only; ESP = Subscriber and Spouse/Life Partner; FAM = Family; SPC= Spouse/Life Partner and Children/ dependents; SPO= Spouse/Life Partner Only.		100%	All
9	CDLME009	Medicaid Aid Category	Text	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.		100%	Medicaid FFS only
10	CDLME010	Subscriber Social Security Number	Text	9	Subscriber's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	Revision to field length: The value reported for this field should include only the last four digits of the subscriber's Social Security number.	95%	All
11	CDLME011	Plan-Specific Contract Number	Text	80	Plan assigned contract number. If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid claim, provide Medicaid ID.	If this is a Medicaid enrollment record, report the Medicaid ID.	100%	All
12	CDLME012	Subscriber Last Name	Text	60	The subscriber's last name.		100%	All
13	CDLME013	Subscriber First Name	Text	35	The subscriber's first name.		100%	All
14	CDLME014	Subscriber Middle Initial	Text	1	The subscriber's middle initial.		5%	All
15	CDLME015	Sequence Number	Text	20	Unique number of the member within the contract. When the member is the subscriber use subscriber sequence number.		0%	All
16	CDLME016	Member Social Security Number	Text	9	Member's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	Revision to field length: The value reported for this field should include only the last four digits of the member's Social Security number. Revision to X12 reference: 271/2100C/REF/SY/02, 271/2100D/REF/SY/02	95%	All
17	CDLME017	Individual Relationship Code	Text	2	Member's relationship to insured. Individual Relationship Code is maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	Revision to X12 reference: 271/2100C/REF/SY/02, 271/2100D/REF/SY/02 The only valid codes for this field are: 01 = Spouse 18 = Self 19 = Child 21 = Unknown 39 = Organ donor 40 = Cadaver donor 53 = Life partner G8 = Other relationship	100%	All
18	CDLME018	Member Gender	Text	1	Gender of the member. M = Male; F = Female; U = UNKNOWN.		100%	All

19	CDLME019	Member Date of Birth	Date	8	Date of birth of the member. CCYYMMDD.		100%	All
20	CDLME020	Member Last Name	Text	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	Revision to X12 reference: 271/2100C/NM1/ /03, 271/2100D/NM1/ /03	100%	All
21	CDLME021	Member First Name	Text	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	Revision to X12 reference: 271/2100C/NM1/ /04, 271/2100D/NM1/ /04	100%	All
22	CDLME022	Member Middle Initial	Text	1	The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.	Revision to X12 reference: 271/2100C/NM1/ /05, 271/2100D/NM1/ /05	5%	All
23	CDLME023	Member Street Address	Text	55	Street address of member's residence.	Use this field to report the first line of the member's street address.	99%	All
24	CDLME024	Member City Name	Text	30	City location of member's residence.		99%	All
25	CDLME025	Member State or Province	Text	2	State or province of member's residence. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.		99%	All
26	CDLME026	Member ZIP Code	Text	9	Report the 5 or 9-digit Zip Code of the member's residence. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.		100%	All
27	CDLME027	Member FIPS County Code	Text	5	Report the FIPS county code based on the members residential address. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. If member lives outside US, leave blank. See Appendix H: External Code Source, United States Census Bureau.		95%	All
28	CDLME028	Member Country Code	Text	2	Country code of member's residence. Code US for United States. See Appendix H: External Code Source, United States Postal Service.		95%	All
29	CDLME029	Race (1)	Text	2	Report the Member-identified race. The code value "UN" (Unknown/not specified), should be used ONLY when Member answers unknown, or refuses to answer. Report only collected data. If not available leave blank. See Appendix G-2: Race 1/Race 2 for codes.		35%	All
30	CDLME030	Race (2)	Text	2	Report the Member-identified race. The code value "UN" (Unknown/not specified), should be used ONLY when Member answers unknown, or refuses to answer. Report only collected data. If not available leave blank. See Appendix G-2: Race 1/Race 2 for codes.		1%	All
31	CDLME031	Race (3)	Text	2	Report the Member-identified race. The code value "UN" (Unknown/not specified), should be used ONLY when Member answers unknown, or refuses to answer. Report only collected data. If not available leave blank. See Appendix G-2: Race 1/Race 2 for codes.		0%	All
32	CDLME032	Hispanic Indicator	Text	1	Report the value that defines the element. The code value "U" for unknown, should be used ONLY when member answers unknown, or refuses to answer.Report only collected data. If not available leave blank. Y = Member is Hispanic/Latino/Spanish; N = Member is not Hispanic/Latino/Spanish; U = Unknown/not specified.		50%	All
33	CDLME033	Ethnicity (1)	Text	6	Report the Member-identified ethnicity from the External Code Source that best describes the information obtained from the Member / Subscriber. The value "UNKNOW" should be used ONLY when the Member answers unknown or refuses to answer.Report only collected data. If not available leave blank. Ethnicity codes are maintained by the Centers for Disease Control and Prevention. See Appendix H: External Code Sources, Centers for Disease Control and Prevention.		35%	All
34	CDLME034	Ethnicity (2)	Text	6	Report the Member-identified ethnicity from either the External Code Source that best describes the information obtained from the Member / Subscriber. The value "UNKNOW" should be used ONLY when the Member answers unknown or refuses to answer.Report only collected data. If not available leave blank. See Appendix H: External Code Sources, Centers for Disease Control and Prevention.		1%	All
35	CDLME035	Ethnicity (Other)	Text	6	Report the Member-identified ethnicity from either the External Code Source that best describes the information obtained from the Member / Subscriber. The value "UNKNOW" should be used ONLY when the Member answers unknown or refuses to answer.Report only collected data. If not available leave blank. Ethnicity codes are maintained by the Centers for Disease Control and Prevention. See Appendix H: External Code Sources, Centers for Disease Control and Prevention.		0%	All
36	CDLME036	Medical Coverage Under This Plan	Text	1	Use this field to indicate whether medical coverage is part of this member's plan (Note: medical coverage may be bundled with other types of coverage) Medical coverage includes any type of coverage besides prescription drug. Y = Yes; N = No.		100%	All
37	CDLME037	Pharmacy Coverage Under This Plan	Text	1	Use this field to indicate whether pharmacy coverage is part of this member's plan (Note: pharmacy coverage may include prescription drugs, supplies and DME; and may be bundled with other types of coverage) Y = Yes; N = No.		100%	All
38	CDLME038	Dental Coverage Under This Plan	Text	1	Use this field to indicate whether dental coverage is part of this member's plan (Note: dental coverage may be bundled with other types of coverage) Y = Yes; N = No.		100%	All
39	CDLME039	Behavioral Health Coverage Under this Plan	Text	1	Use this field to indicate whether behavioral health coverage is part of this member's plan (Note: behavioral health coverage may be bundled with other types of coverage). Valid codes include: Y = Yes; N = No.		100%	All
40	CDLME040	Primary Insurance Indicator	Text	1	Use this field to report whether the policy for this eligibility record is the primary insurance for the member. Y = Yes, primary insurance; N = No, this is not the member's primary insurance.		100%	All
41	CDLME041	Coverage Type	Text	3	This field identifies which entity holds the risk: ASW = Self-funded plans administered by a TPA, where the employer has purchased stop-loss, or group excess insurance coverage; ASO = Self- funded plans administered by a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage; STN = Short-term, non-renewable health insurance (e.g., COBRA); UND = Plans underwritten by the insurer(fully insured group and individual policies); MEW = Associations/Trusts and Multiple Employer Welfare Arrangements; OTH = Any other plan (for example-student health plan). Insurers using this code shall obtain prior approval.	Medicaid plans should report as 'OTH' (Any other plan).	100%	All
42	CDLME042	Plan State	Text	2	State in which the plan is sold/sitused. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.		100%	All
43	CDLME043	Market Category Code	Text	4	Code for identifying market category. See Appendix G- 3: Market Category Codes which defines the market category by size and or association to which the policy is directly sold and issued. Report subscribers (not employees).		100%	All
44	CDLME044	Special Coverage	Text	6	Reserved for specific state coverage. 0 = Not applicable; XXXXXX = Specific state coverage.		0%	All
45	CDLME045	Group Name	Text	60	Name of the group which is covering the member (the name established in the payer's system and not the full legal name). If the member is part of a group of one, or non-group, then use IND.	If a policy is sold to an individual as a non-group policy, then both the Insured Group or Policy Number (CDLME007) and Group Name (CDLME045) should be reported with a value of 'IND'. Medicaid and Medicare plans follow this same principle and should be reported as 'IND'.	95%	All
46	CDLME046	Member PCP ID	Text	35	Unique code identified for the Primary Care Provider (PCP) This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank.		100%	PCP Assignment (CDLME048) = 1 or 2
47	CDLME047	NPI of Member's PCP	Long	10	NPI of the member's Primary Care Provider. If not applicable, leave blank.		100%	PCP Assignment (CDLME048) = 1 or 2
48	CDLME048	PCP Assignment	Text	1	1 = PCP in CDLME046 was selected by the member; 2= PCP in CDLME046 was attributed by the health plan; 3 = PCP is not selected, and no services rendered; 4 = PCP is not assigned/ unknown.		100%	All

49	CDLME049	Member PCP Effective Date	Date	8	Primary Care Provider Effective Date with member if CDLME048=1 or 2 (PCP Assignment). Report the date in CCYYMMDD format. If not applicable, leave blank.		0%	PCP Assignment (CDLME048) = 1 or 2
50	CDLME050	Plan Effective Date	Date	8	CCYYMMDD. Effective date of coverage; Date eligibility started for this member under this plan type. The purpose of this data element is to maintain an eligibility span for each member.		100%	All
51	CDLME051	Plan Term Date	Date	8	CCYYMMDD. Last continuous day of coverage (date eligibility ended) for this member under this plan. The purpose of this data element is to maintain an eligibility span for each member. For open contracts, leave blank.		2%	All
52	CDLME052	HIOS Plan Indicator	Text	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Is the member enrolled in a Health Insurance Oversight System plan? 1=Yes; 2=No; 3=Unknown/not applicable.		100%	All
53	CDLME053	HIOS Plan ID	Text	16	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Health Insurance Oversight System ID. Required for qualified health plans (QHPs) as defined in the Patient Protection and Affordable Care Act (ACA). If CDLME051 is NOT=1 or 2, leave blank. The HIOS Plan ID (Standard Component) includes a five-digit issuer ID, two-character state ID, 3-digit product number, four digit standard component number and two digit variant component ID. This field may not be available for all market segments. If not applicable, leave blank.		100%	HIOS Plan Indicator (CDLME052) = 1
54	CDLME054	Metal Tier	Text	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements: 0=Not a QHP or catastrophic plan; 1=Catastrophic; 2=Bronze; 3=Silver; 4=Gold; 5=Platinum. If not applicable, leave blank.		100%	Enrolled Through a Public Health Insurance Exchange (CDLME057) = 1
55	CDLME055	Medical Home Indicator	Text	1	Use this field to report whether the member had a medical home on record for this coverage period. If not stored in payer system, use code '3'. Valid codes include: 1=Yes; 2=No; 3=Unknown/not applicable.		100%	All
56	CDLME056	Payer-Assigned ID for Medical Home	Text	30	Unique code identified for the Medical Home (as assigned by the reporting entity). Payer assigned ID for the Medical Home is for the Medical Home to which the member belongs. Payer assigned ID for the Medical Home is the identifier used by the payer for internal identification purposes and does not routinely change. Must correspond to a Payer Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank.		100%	Medical Home Indicator (CDLME055) = 1
57	CDLME057	Enrolled Through a Public Health Insurance Exchange	Text	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Use this field to report whether the policy for this eligibility record was enrolled through a Public Health Insurance Exchange. Valid codes include: 1=Yes; 2=No; 3=Unknown/ not applicable.		100%	All
58	CDLME058	Employer Tax ID	Text	10	Subscriber's employer EIN or SSN. If coverage not purchased through or enrolled by an employer, leave blank. If not received leave blank.		95%	Market Category Code (CDLME043) = GS1, GS2, GS3, GS4, GLG1, GLG2, GLG3, GLG4, GSA
59	CDLME059	Employment Status	Text	1	Report the code that defines the employment status of the member/subscriber: A=Active; I=Involuntary Leave; P=Pending; R=Retiree; Z=Unemployed; U=Unknown.		100%	Market Category Code (CDLME043) = GS1, GS2, GS3, GS4, GLG1, GLG2, GLG3, GLG4, GSA
60	CDLME060	Employer ZIP Code	Text	9	Report the 5 or 9-digit Zip Code of the employer (as reported in CDLME058) When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. If coverage not purchased through or enrolled by an employer, leave blank. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Source.		95%	Market Category Code (CDLME043) = GS1, GS2, GS3, GS4, GLG1, GLG2, GLG3, GLG4, GSA
61	CDLME061	Carrier Specific Unique Member ID	Text	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.		100%	All
62	CDLME062	Carrier Specific Unique Subscriber ID	Text	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.		100%	All
63	CDLME063	NAIC ID	Text	5	Report the NAIC Code associated with the entity that maintains this product. Leave blank if entity does not have a NAIC Code. See Appendix H: External Code Source; NAIC codes are maintained by the National Association of Insurance Commissioners.		100%	All
64	CDLME064	High-Deductible Plan Indicator	Text	1	High deductible plan as defined by the IRS at start of plan year. Valid codes include: Y=Yes; N=No. If not applicable, leave blank.		99%	All
65	CDLME065	Total Monthly Premium Amount	Decimal	12	For fully-insured premiums, report the monthly fee paid by a subscriber and/or employer for health insurance coverage for a given number of members (e.g. individual, individual plus one, family), prior to any medical loss ratio rebate payments, but inclusive of any fees paid to a third party (e.g., exchange fees, reinsurance). Report the total monthly premium at the Subscriber level only. Do not report on member lines. Report 0 if no premium is charged. Do not code decimal point or provide any punctuation (e.g.,$1,000.25 converted to 100025).		1%	All
66	CDLME066	Actuarial Value	Text	6, 4	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Report value as calculated in the most recent version of the HHS Actuarial Value Calculator. Include decimal point with reported value. Format to be used is 0.0000. For example, an AV of 88.27689% should be reported as 0.8828. Required as of January 1, 2014, for small group and non-group (individual) plans sold inside or outside the Exchange. If not applicable, leave blank.See Appendix H: External Code Source, Centers for Medicaid and Medicare Services.		95%	HIOS Plan Indicator (CDLME052) = 1
67	CDLME067	Grandfathered Plan Indicator	Text	1	Indicates if a plan qualifies as a "Grandfathered" or "Transitional Plan" under the Affordable Care Act (ACA). Please see definition for "grandfathered" and "transitional" in HHS rules 45-CFR-147.140: https://www.federalregister.gov/select- citation/2013/06/03/45-CFR-147. The values of the indicator are as follows: 1= Grandfathered; 2 = Non- Grandfathered; 3 =Transitional; 4 = Not Applicable.		100%	All
68	CDLME068	Cost-Sharing Reduction Indicator	Text	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Indicates cost-sharing reduction under the Affordable Care Act (ACA). This is a person- level indicator in which enrollees who qualify for cost-sharing reduction are assigned cost- sharing indicator values of 1-8. Non- Cost-Sharing recipients are assigned a cost-sharing indicator value of zero. Valid codes include: 1 = Enrollees in 94% Actuarial Value (AV) Silver Plan Variation; 2 = Enrollees in 87% AV Silver Plan Variation; 3 = Enrollees in 73% AV Silver Plan Variation; 4 = Enrollees in Zero Cost Sharing Plan Variation of Platinum Level QHP (Qualified Health Plan); 5 = Enrollee in Zero Cost Sharing Plan Variation of Gold Level QHP; 6 = Enrollee in Zero Cost Sharing Plan Variation of Silver Level QHP; 7 = Enrollee in Zero Cost Sharing Plan Variation of Bronze Level QHP; 8 = Enrollee in Limited Cost Sharing Plan Variation; 0 = Non-CSR recipient, and enrollees with unknown CSR.		95%	HIOS Plan Indicator (CDLME052) = 1
69	CDLME069	Administrative Service Fees	Decimal	12	Administrative Service Fees (ASFs): Average monthly fee paid by an employer to cover its self- insured health plan administration, excluding any stop-loss premiums, and divided by the number of members under administration. Administrator services for these fees may vary, including plan design and network access, claims adjudication and administration, and/or population health management. Primary reporting goal will be to monitor self-insured coverage costs over time, using ASFs as one component of a "premium- equivalent." Report 0 if no fee is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Required when CDLME041 =ASW or ASO.		0%	All

70	CDLME070	Tiered Network	Text	1	Tiered Network: Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality and/or the cost of care provided. Tiers are not considered separate networks, but rather sub-segments of a payer's HMO or PPO network. A tiered network is different than a plan only splitting benefits by in- network vs. out-of-network; a tiered network will have varying degrees of payments of in-network providers. Report the code that defines the tier network of the member/subscriber' plan: 0 = Limited Network; 1 = Single Tier-Not tiered; 2 = Two Tier; 3 = Three Tier; 4 = Four Tier; 5 = Other.		0%	All
71	CDLME071	Member Income Frequency Code	Text	1	Report the frequency for the member income as reported at enrollment: 1 = Weekly; 2 = Bi-Weekly; 3= Semi-Monthly; 4 = Monthly; 6 = Daily; 7 = Annually; 8 = Two calendar months; 9 = Lump sum separation allowance.		0%	All
72	CDLME072	Member Income Monetary Amount	Decimal	12	Member's income as reported during enrollment. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).		0%	All
73	CDLME073	Member Primary Language	Text	3	Report the primary language of the member. See Appendix H: External Code Source, ISO 639 Language Codes		5%	All
74	CDLME074	Placeholder	Text	11	Subscriber's Medicare Beneficiary Identifier. Required only for Medicare Supplemental/Companion Plans.Otherwise, leave blank.	Report as null.	0%	All
75	CDLME075	Member Medicare Beneficiary Identifier	Text	11	Member's Medicare Beneficiary Identifier. Required only for Medicare Supplemental/Companion Plans for which 1) the subscriber and the member are not the same person, 2) the payer is primary. Otherwise, leave blank.	Required for all Medicare members (e.g., Medicare Advantage, Medicare supplemental).	100%	Member Insurance / Product Category Code (CDLME004) = AB, E, HN, MA, MB, MD, MO, SP
76	CDLME076	ACO Identifier	Text	30	APCD agencies will provide guidance as to what values are to be reported in this field	Use this field to report the ACO ID (aco_id) for the applicable ACO using the IDs maintained by CMS. To access the proper ID, please visit the following link and use its "Basic Filtering" option to select the following sequence: aco_service_area > Contains > IN Link: https://data.cms.gov/medicare-shared-savings-program/accountable-care-organizations/data	100%	State-specific
77	CDLME077	ACO Name	Text	60	APCD agencies will provide guidance as to what values are to be reported in this field	Use this field to report the ACO Name (aco_name) for the ACO identified above in CDLME076 (ACO Identifier) using the names maintained by CMS. To access the proper name, please visit the following link and use its "Basic Filtering" option to select the following sequence: aco_service_area > Contains > IN Link: https://data.cms.gov/medicare-shared-savings-program/accountable-care-organizations/data	100%	State-specific
78	CDLME078	Physician Organization Identifier	Text	30	For managed care members assigned a PCP, the identifier of the physician group or provider organization or to which the PCP belongs. APCD agencies may provide state-specific guidance on what IDs to use		100%	State-specific
79	CDLMEXXX	Placeholder	N/A	N/A	Reserved for future use. Elements will only be added with review from states and payers.		0%	All
80	CDLME899	Record Type	Text	2	Value = ME.		100%	All

Medical Claims

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Col. #	Field ID	Field Name	Type	Max. Length	APCD-CDL Guidance	Notes on IN-Specific Guidance to Submitters	Threshold	Condition (Denominator)
1	CDLMC001	Data Submitter Code	Text	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLMC002).	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For the Indiana APCD, valid prefixes include: INC = Commercial carrier ING = Governmental agency INT = Third-party administrator / pharmacy benefits manager Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	All
2	CDLMC002	Placeholder	Text	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	Report as null.	0%	All
3	CDLMC003	Placeholder	Text	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	Report as null.	0%	All
4	CDLMC004	Member Insurance / Product Category Code	Text	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available.	The only valid product codes for reporting are: AB = Medicare Part A & B (Medicare FFS only) E = Medicare - Point of Service (POS) EP = Exclusive Provider Organization FH = Federal Employees Health Benefits Program (HMO) FP = Federal Employees Health Benefits Program (PPO) HM = Health Maintenance Organization (HMO) HN = Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C IN = Indemnity MA = Medicare Part A (Medicare FFS Only) MB = Medicare Part B (Medicare FFS Only) MC = Medicaid MD = Medicare Part D MO = Medicare Advantage PPO PR = Preferred Provider Organization (PPO) PS = Point of Service (POS) SP = Medicare Supplemental Policy	100%	All
5	CDLMC005	Payer Claim Control Number	Text	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLMC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.		100%	All
6	CDLMC006	Line Counter	Integer	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.		100%	All
7	CDLMC007	Version Number	Integer	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, Cross Reference Claims ID (CDLMC008) is to be utilized.	Use this field to report the version number of the claim service record. The version number begins with 0, and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, code as '0'.	100%	All
8	CDLMC008	Cross-Reference Claims ID	Text	35	The original Payer Claim Control Number (CDLMC005). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLMC007) is not used.		0%	All
9	CDLMC009	Insured Group or Policy Number	Text	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLME007 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	If a policy is sold to an individual as a non-group policy, report with a value of 'IND'. Medicaid and Medicare plans follow this same principle and should be reported as 'IND'.	99%	All
10	CDLMC010	Medicaid Aid Category	Text	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.		100%	Medicaid FFS only
11	CDLMC011	Subscriber Social Security Number	Text	9	Subscriber's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	Revision to field length: The value reported for this field should include only the last four digits of the subscriber's Social Security number.	95%	All
12	CDLMC012	Plan-Specific Contract Number	Text	80	Plan assigned contract number. Leave blank if Plan Specific Contract Number is the subscriber's Social Security Number. If this is a Medicaid claim, provide Medicaid ID.		100%	All
13	CDLMC013	Subscriber Last Name	Text	60	The subscriber's last name.		100%	All
14	CDLMC014	Subscriber First Name	Text	35	The subscriber's first name.		100%	All
15	CDLMC015	Sequence Number	Text	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.		0%	All
16	CDLMC016	Member Social Security Number	Text	9	Member's Social Security Number - do not include dashes; Required if collected. If not available, leave blank.	Revision to field length: The value reported for this field should include only the last four digits of the member's Social Security number.	95%	All
17	CDLMC017	Individual Relationship Code	Text	2	Member's relationship to insured. Individual Relationship codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, see Accredited Standards Committee.	X12 reference: 271/2100C/REF/SY/02, 271/2100D/REF/SY/02 The only valid codes for this field are: 01 = Spouse 18 = Self 19 = Child 21 = Unknown 39 = Organ donor 40 = Cadaver donor 53 = Life partner G8 = Other relationship	100%	All
18	CDLMC018	Member Gender	Text	1	Gender of Member M = Male; F = Female; U = Unknown.		100%	All
19	CDLMC019	Member Date of Birth	Date	8	CCYYMMDD; Date of birth of member.		100%	All
20	CDLMC020	Member Last Name	Text	60	The member's last name. If the member is the subscriber, report the subscriber's last name.		100%	All
21	CDLMC021	Member First Name	Text	35	The member's first name. If the member is the subscriber, report the subscriber's first name.		100%	All
22	CDLMC022	Member ZIP Code	Text	9	Report the 5 or 9-digit Zip Code of the member's residence. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.		100%	All

23	CDLMC023	Patient Control Number	Text	20	Patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services.		90%	All
24	CDLMC024	Paid Date	Date	8	CCYYMMDD. Paid date of the claim line. Report the date that appears on the: check, and/or remit, and/or explanation of benefits, and corresponds to any and all types of payment in CCYYMMDD Format. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here.	X12 reference: 835/Header Financial Information/BPR/ /16	100%	All
25	CDLMC025	Admission Date	Date	8	CCYYMMDD. Required for all inpatient claims, this is the date of admission. For professional claims leave blank.		100%	Institutional inpatient
26	CDLMC026	Admission Hour	Text	4	HHMM. (Military time) The hour during which the patient was admitted for inpatient care. For professional claims leave blank.		100%	Acute inpatient
27	CDLMC027	Admission Type	Text	1	Required for all inpatient claims. Valid codes are: 1= Emergency; 2 = Urgent; 3 = Elective; 4 = Newborn; 5 = Trauma Center; 9 = Information not available. For professional claims, leave blank.Admission Type codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.		100%	Acute inpatient
28	CDLMC028	Point of Origin	Text	1	A code indicating the point of patient origin for this admission or visit. Required for all institutional claims. Admission Type codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.		100%	Acute inpatient
29	CDLMC029	Discharge Date	Date	8	CCYYMMDD. Date patient discharged. Required for all inpatient claims.		100%	Institutional inpatient
30	CDLMC030	Discharge Hour	Text	4	HHMM (Military time). The hour during which the patient was discharged from inpatient care. For professional claims, leave blank.		100%	Acute inpatient and Discharge Status (CDLMC031) ≠ 30 (Still Patient)
31	CDLMC031	Discharge Status	Text	2	Required for all institutional claims. Discharge Status codes are maintained by NUBC. For professional claims, leave blank. See Appendix H: External Code Source, National Uniform Billing Committee.		100%	Institutional inpatient
32	CDLMC032	Type of Bill - Institutional	Text	3	Required for institutional claims. Not to be used for professional claims. As defined by the National Uniform Billing Committee. Do not include the leading zero. Type of Bill codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.		100%	Institutional
33	CDLMC033	Place of Service - Professional	Text	2	Required for professional claims. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix H: External Code Source, Center for Medicaid and Medicare Services.		100%	Professional
34	CDLMC034	Admitting Diagnosis	Text	7	The ICD code describing the patient's diagnosis at the time of admission. Required on all inpatient admission claims and encounters. Codes found in ICD-9-CM or ICD -10-CM. Do not code decimal point. See Appendix H: External Code Source, World Health Organization.		100%	Institutional inpatient
35	CDLMC035	First External Cause Code	Text	7	The ICD diagnosis codes pertaining to environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. As submitted by provider in the first external cause field- if not submitted by the provider or captured by the carrier leave blank. Codes found in ICD-9-CM or ICD -10-CM. Do not code decimal point. See Appendix H: External Code Source, World Health Organization.		5%	Institutional
36	CDLMC036	ICD Version Indicator	Text	1	The purpose of this field is to identify which code set is being utilized. 9 = This claim contains ICD-9- CM codes. 0= This claim contains ICD-10-CM codes.		100%	All
37	CDLMC037	Principal Diagnosis	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. Cannot include codes V00-Y99. See Appendix H: External Code Source.		100%	All
38	CDLMC038	Other Diagnosis - 1	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		40%	All
39	CDLMC039	Other Diagnosis - 2	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		25%	All
40	CDLMC040	Other Diagnosis - 3	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		15%	All
41	CDLMC041	Other Diagnosis - 4	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		10%	All
42	CDLMC042	Other Diagnosis - 5	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		5%	All
43	CDLMC043	Other Diagnosis - 6	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		1%	All
44	CDLMC044	Other Diagnosis - 7	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	All
45	CDLMC045	Other Diagnosis - 8	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	All
46	CDLMC046	Other Diagnosis - 9	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	All
47	CDLMC047	Other Diagnosis - 10	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	All
48	CDLMC048	Other Diagnosis - 11	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	All
49	CDLMC049	Other Diagnosis - 12	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
50	CDLMC050	Other Diagnosis - 13	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
51	CDLMC051	Other Diagnosis - 14	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
52	CDLMC052	Other Diagnosis - 15	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
53	CDLMC053	Other Diagnosis - 16	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
54	CDLMC054	Other Diagnosis - 17	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
55	CDLMC055	Other Diagnosis - 18	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
56	CDLMC056	Other Diagnosis - 19	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
57	CDLMC057	Other Diagnosis - 20	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
58	CDLMC058	Other Diagnosis - 21	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
59	CDLMC059	Other Diagnosis - 22	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
60	CDLMC060	Other Diagnosis - 23	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
61	CDLMC061	Other Diagnosis - 24	Text	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Institutional
62	CDLMC062	Present on Admission Code - 1	Text	1	Present on Admission Indicator Principal Diagnosis For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Principal Diagnosis (CDLMC037) is not null

63	CDLMC063	Present on Admission Code - 2	Text	1	POA Indicator for Other Diagnosis – 1. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 1 (CDLMC038) is not null
64	CDLMC064	Present on Admission Code - 3	Text	1	POA Indicator for Other Diagnosis – 2. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 2 (CDLMC039) is not null
65	CDLMC065	Present on Admission Code - 4	Text	1	POA Indicator for Other Diagnosis – 3. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 3 (CDLMC040) is not null
66	CDLMC066	Present on Admission Code - 5	Text	1	POA Indicator for Other Diagnosis – 4. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 4 (CDLMC041) is not null
67	CDLMC067	Present on Admission Code - 6	Text	1	POA Indicator for Other Diagnosis – 5. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 5 (CDLMC042) is not null
68	CDLMC068	Present on Admission Code - 7	Text	1	POA Indicator for Other Diagnosis – 6. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 6 (CDLMC043) is not null
69	CDLMC069	Present on Admission Code - 8	Text	1	POA Indicator for Other Diagnosis – 7. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 7 (CDLMC044) is not null
70	CDLMC070	Present on Admission Code - 9	Text	1	POA Indicator for Other Diagnosis – 8. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 8 (CDLMC045) is not null
71	CDLMC071	Present on Admission Code - 10	Text	1	POA Indicator for Other Diagnosis – 9. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 9 (CDLMC046) is not null
72	CDLMC072	Present on Admission Code - 11	Text	1	POA Indicator for Other Diagnosis – 10. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 10 (CDLMC047) is not null
73	CDLMC073	Present on Admission Code - 12	Text	1	POA Indicator for Other Diagnosis – 11. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 11 (CDLMC048) is not null
74	CDLMC074	Present on Admission Code - 13	Text	1	POA Indicator for Other Diagnosis – 12 For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 12 (CDLMC049) is not null
75	CDLMC075	Present on Admission Code - 14	Text	1	POA Indicator for Other Diagnosis – 13. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 13 (CDLMC050) is not null
76	CDLMC076	Present on Admission Code - 15	Text	1	POA Indicator for Other Diagnosis – 14. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 14 (CDLMC051) is not null
77	CDLMC077	Present on Admission Code - 16	Text	1	POA Indicator for Other Diagnosis – 15. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 15 (CDLMC052) is not null
78	CDLMC078	Present on Admission Code - 17	Text	1	POA Indicator for Other Diagnosis – 16. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 16 (CDLMC053) is not null
79	CDLMC079	Present on Admission Code - 18	Text	1	POA Indicator for Other Diagnosis – 17. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 17 (CDLMC054) is not null
80	CDLMC080	Present on Admission Code - 19	Text	1	POA Indicator for Other Diagnosis – 18. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 18 (CDLMC055) is not null
81	CDLMC081	Present on Admission Code - 20	Text	1	POA Indicator for Other Diagnosis – 19. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 19 (CDLMC056) is not null
82	CDLMC082	Present on Admission Code - 21	Text	1	POA Indicator for Other Diagnosis – 20. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 20 (CDLMC057) is not null
83	CDLMC083	Present on Admission Code - 22	Text	1	POA Indicator for Other Diagnosis – 21. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 21 (CDLMC058) is not null
84	CDLMC084	Present on Admission Code - 23	Text	1	POA Indicator for Other Diagnosis – 22. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 22 (CDLMC059) is not null
85	CDLMC085	Present on Admission Code - 24	Text	1	POA Indicator for Other Diagnosis – 23. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 23 (CDLMC060) is not null
86	CDLMC086	Present on Admission Code - 25	Text	1	POA Indicator for Other Diagnosis – 24. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N= No; U=Unknown; W = Not Applicable.		95%	Acute inpatient and Other Diagnosis - 24 (CDLMC061) is not null
87	CDLMC087	Revenue Code	Text	4	Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements. NUBC Code using leading zeroes, left justified, and four digits. For institutional claims only. Not for professional claims. Revenue codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.		100%	Institutional
88	CDLMC088	Procedure Code	Text	5	Healthcare Common Procedural Coding System (HCPCS). This includes the CPT codes maintained by the American Medical Association. This field should not include modifiers. Modifiers are submitted in different fields. See Appendix H: External Code Source, American Medical Association.	X12 reference: 835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2	100%	Professional and institutional outpatient
89	CDLMC089	Procedure Modifier - 1	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	X12 reference: 835/2110/SVC/HC/01-3	15%	Procedure Code (CDLMC088) is not null
90	CDLMC090	Procedure Modifier - 2	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	X12 reference: 835/2110/SVC/HC/01-4	5%	Procedure Code (CDLMC088) is not null and Procedure Modifier - 1 (CDLMC089) is not null

91	CDLMC091	Procedure Modifier - 3	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	X12 reference: 835/2110/SVC/HC/01-5	5%	Procedure Code (CDLMC088) is not null and Procedure Modifier - 2 (CDLMC090) is not null
92	CDLMC092	Procedure Modifier - 4	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	X12 reference: 835/2110/SVC/HC/01-6	5%	Procedure Code (CDLMC088) is not null and Procedure Modifier - 3 (CDLMC091) is not null
93	CDLMC093	ICD-9 CM/10-CM-PCS Principal Procedure Code	Text	7	Primary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		55%	Acute inpatient
94	CDLMC094	ICD-9 CM/10-CM-PCS Other Procedure Code - 1	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		25%	Acute inpatient
95	CDLMC095	ICD-9 CM/10-CM-PCS Other Procedure Code - 2	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
96	CDLMC096	ICD-9 CM/10-CM-PCS Other Procedure Code - 3	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
97	CDLMC097	ICD-9 CM/10-CM-PCS Other Procedure Code - 4	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
98	CDLMC098	ICD-9 CM/10-CM-PCS Other Procedure Code - 5	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
99	CDLMC099	ICD-9 CM/10-CM-PCS Other Procedure Code - 6	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
100	CDLMC100	ICD-9 CM/10-CM-PCS Other Procedure Code - 7	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
101	CDLMC101	ICD-9 CM/10-CM-PCS Other Procedure Code - 8	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
102	CDLMC102	ICD-9 CM/10-CM-PCS Other Procedure Code - 9	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
103	CDLMC103	ICD-9 CM/10-CM-PCS Other Procedure Code - 10	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
104	CDLMC104	ICD-9 CM/10-CM-PCS Other Procedure Code - 11	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
105	CDLMC105	ICD-9 CM/10-CM-PCS Other Procedure Code - 12	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
106	CDLMC106	ICD-9 CM/10-CM-PCS Other Procedure Code - 13	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
107	CDLMC107	ICD-9 CM/10-CM-PCS Other Procedure Code - 14	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
108	CDLMC108	ICD-9 CM/10-CM-PCS Other Procedure Code - 15	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
109	CDLMC109	ICD-9 CM/10-CM-PCS Other Procedure Code - 16	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
110	CDLMC110	ICD-9 CM/10-CM-PCS Other Procedure Code - 17	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
111	CDLMC111	ICD-9 CM/10-CM-PCS Other Procedure Code - 18	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
112	CDLMC112	ICD-9 CM/10-CM-PCS Other Procedure Code - 19	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
113	CDLMC113	ICD-9 CM/10-CM-PCS Other Procedure Code - 20	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
114	CDLMC114	ICD-9 CM/10-CM-PCS Other Procedure Code - 21	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
115	CDLMC115	ICD-9 CM/10-CM-PCS Other Procedure Code - 22	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
116	CDLMC116	ICD-9 CM/10-CM-PCS Other Procedure Code - 23	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
117	CDLMC117	ICD-9 CM/10-CM-PCS Other Procedure Code - 24	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient
118	CDLMC118	ICD-9 CM/10-CM-PCS Other Procedure Code - 25	Text	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.		0%	Acute inpatient

119	CDLMC119	Date of Service - From	Date	8	CCYYMMDD. First date of service for this service line. Filled for all claim types. (This date should be within the coverage period on the Eligibility file i.e. between the Plan Effective Date and the Plan Term Date on the Eligibility file all inclusive).		100%	All
120	CDLMC120	Date of Service - Through	Date	8	CCYYMMDD Last date of service for this service line. Filled for all claim types.		100%	All
121	CDLMC121	Service Units / Quantity	Decimal	12,3	Count of service units performed. 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.	Use this field to report the total units of measure for the individual type of service being performed, including those for observation stays and room and board service lines. The unit of measure should be based on the relevant reporting code (e.g., CPT, revenue, HCPCS). For example: • Anesthesiology = Minutes • Ambulance = Miles • Room and board = Days Include the decimal. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
122	CDLMC122	Unit of Measure	Text	2	Type of units reported in CDLMC121.Example codes: DA=Days; MJ= Minutes; UN=Units. If CDLMC121 is blank (not reported), leave CDLMC122 blank.		100%	All
123	CDLMC123	Charge Amount	Decimal	12	The amount charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
124	CDLMC124	Withhold Amount	Decimal	12	A claim-based payment that is included in total medical expense. Report the amount paid to the provider for this claim line if the provider qualified/ met performance guarantees. Report 0 if there is no withhold amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
125	CDLMC125	Plan Paid Amount	Decimal	12	This is the amount paid by the plan to cover the services, to the provider or member. This excludes the patient liability. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
126	CDLMC126	Copay Amount	Decimal	12	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the co-pay amount on the first claim line. Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
127	CDLMC127	Coinsurance Amount	Decimal	12	The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g.,$1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
128	CDLMC128	Deductible Amount	Decimal	12	Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
129	CDLMC129	Other Insurance Paid Amount	Decimal	12	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report "0" if the prior payer paid 0 toward this claim line; or if there is no prior payer. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
130	CDLMC130	COB/TPL Amount	Decimal	12	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
131	CDLMC131	Allowed Amount	Decimal	12	When payment arrangement type in CDLMC132 is equal to 01 for capitated services, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. When payment arrangement type in CDLMC132 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service.Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
132	CDLMC132	Payment Arrangement Type Indicator	Text	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 04=DRG; 05=Pay for Performance; 06=Global Payment; 07=Other; 08=Bundled Payment.		100%	All
133	CDLMC133	Drug Code	Text	11	Report the NDC code only when a medication is paid for as part of a medical claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. If not available, leave blank. See Appendix H: External Code Source, United States Food and Drug Administration.		1%	All
134	CDLMC134	Rendering Provider ID	Text	35	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that provided the services on the claims. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	X12 reference: 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/PC/09, 835/2100/NM1/MC/09, 835/2100/NM1/BS/09	100%	All
135	CDLMC135	Rendering Provider NPI	Long	10	Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES.	X12 reference: 835/2100/NM1/XX/09	100%	All
136	CDLMC136	Rendering Provider Entity Type Qualifier	Text	1	Use this field to indicate whether the rendering provider is a person or "non-person entity. 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." Valid codes are: 1 = Person; 2 = Non-Person Entity.	X12 reference: 835/2100/NM1/82/02	100%	All
137	CDLMC137	In-Plan Network Indicator	Text	1	A yes/no indicator that specifies if the provider (not the benefit) is within the health plan network. Valid codes are: N=No; Y=Yes; L=Leased Network.		100%	All
138	CDLMC138	Rendering Provider First Name	Text	35	Individual first name. If CDLMC136=2, leave blank.	X12 reference: 835/2100/NM1/82/04	100%	Rendering Provider Entity Type Qualifier (CDLMC136) = 1
139	CDLMC139	Rendering Provider Middle Name	Text	25	Individual middle name or initial. If CDLMC136=2, leave blank.	X12 reference: 835/2100/NM1/82/05	1%	Rendering Provider Entity Type Qualifier (CDLMC136) = 1
140	CDLMC140	Rendering Provider Last Name or Organization Name	Text	60	Full name of provider organization ("non-person entity") or last name of individual ("person") provider. CDLMC136 determines if the Rendering Provider is a "person" or a "non-person entity".	X12 reference: 835/2100/NM1/82/03	100%	All
141	CDLMC141	Rendering Provider Suffix	Text	10	Suffix of Rendering Provider. Leave blank if provider is a facility or organization. The rendering provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD.	X12 reference: 835/2100/NM1/82/07	0%	Rendering Provider Entity Type Qualifier (CDLMC136) = 1
142	CDLMC142	Rendering Provider Specialty	Text	10	Standard code that identifies the provider specialty for this line of service. Report the HIPAA- compliant healthcare provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix H: External Code Source, National Uniform Claims Committee.	X12 reference: Institutional: 837/2000A/PRV/PXC/03 Professional 837/2310B/PRV/PXC/03	95%	All

143	CDLMC143	Rendering Provider City Name	Text	30	City name of provider or service facility location.		99%	All
144	CDLMC144	Rendering Provider State or Province	Text	2	State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.		99%	All
145	CDLMC145	Rendering Provider ZIP Code	Text	9	Report the 5 or 9-digit Zip Code of the Rendering Provider. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources		100%	All
146	CDLMC146	Rendering Provider Group Practice NPI	Long	10	NPI of group practice to which a rendering provider is affiliated if different from CDLMC135.		1%	Rendering Provider Entity Type Qualifier (CDLMC136) = 1
147	CDLMC147	Billing Provider ID	Text	30	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	X12 reference: 837/2010BB/REF/G2/02	100%	All
148	CDLMC148	Billing Provider NPI	Long	10	NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	X12 reference: 837/2010AA/NM1/XX/09	100%	All
149	CDLMC149	Billing Provider Last Name or Organization Name	Text	60	Full name of provider billing organization or last name of individual billing provider.		100%	All
150	CDLMC150	Billing Provider Tax ID	Text	10	Tax ID of the billing provider. Do not code punctuation.	X12 reference: 837/2010AA/REF/EI/02, 837/2010AA/REF/SY/02	90%	All
151	CDLMC151	Referring Provider ID	Text	30	Payer assigned provider ID for the referring provider. The Referring Provider is the provider who directed the patient for care to the provider that rendered the services being submitted on the claim form. The Referring Provider Number is the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not available, leave blank.	X12 reference: Institutional 837/2310F/REF/G2/02 Professional 837/2310A/REF/G2/02	10%	All
152	CDLMC152	Referring Provider NPI	Long	10	NPI of the referring provider. The referring provider is the entity or individual that submitted the referral of the service or procedure. The Referring Provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form. If not available, leave blank.	X12 reference: Institutional 837/2310F/NM1/XX/09 Professional 837/2310A/NM1/XX/09	10%	All
153	CDLMC153	Attending Provider ID	Text	30	Payer assigned provider ID for the attending provider. On the institutional claim, the Attending Provider is the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending Provider Number is the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not available, leave blank.	X12 reference: Institutional 837/2310A/REF/G2/02	10%	Acute Inpatient
154	CDLMC154	Attending Provider NPI	Long	10	NPI of the attending provider. The Attending Provider on an 837I claim represents the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending and Rendering provider can be the same individual. If not available, leave blank.	X12 reference: Institutional 837/2310A/NM1/XX/09	10%	Acute Inpatient
155	CDLMC155	Carrier Associated with Claim	Text	8	For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved- out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. If not available, leave blank. See Appendix H: External Code Source, National Association of Insurance Commissioners.		0%	All
156	CDLMC156	Type of Claim	Text	1	Indicates the type of claim that was submitted. Valid codes are: 1=Professional; 2=Institutional/ Facility; 3=Reimbursement Form (Member).		100%	All
157	CDLMC157	Claim Status	Text	2	Claim status codes maintained by ANSI ASC X12 is the code identifying type of claim. See Appendix H: External Code Source, Accredited Standards Committee.	Use this field to report the status of the claim line (i.e., whether paid as primary, paid as secondary, denied, etc.). Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set. The only valid codes for this field are: 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 X12 reference: 835/2100/CLP/ /02	100%	All
158	CDLMC158	Denied Claim Line Indicator	Text	1	Use this field to indicate whether the payer denied this specific line on this specific claim. Valid codes are: 1=Yes (denied); 2= No (not denied).		100%	All
159	CDLMC159	Claim Adjustment Reason Code	Text	3	Report the claim adjustment reason code. If CDLMC158=1, report the code that defines the reason for denial of the claim line. If not available, leave blank. Reason codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.		20%	Denied Claim Line Indicator (CDLMC158) = 1
160	CDLMC160	Claim Line Type	Text	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment; D=Denial.		100%	All
161	CDLMC161	Carrier-Specific Unique Member ID	Text	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.		100%	All
162	CDLMC162	Carrier-Specific Unique Subscriber ID	Text	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.		100%	All
163	CDLMC163	Rendering Provider Street Address	Text	55	Street address where the rendering provider delivered the service (street number and street name). Include suite number if applicable.	Use this field to report the first line of the street address where the service was rendered.	90%	All
164	CDLMCXXX	Placeholder	N/A	N/A	Reserved for future use. Elements will only be added with review from states and payers.		0%	All
165	CDLMC899	Record Type	Text	2	Value = MC.		100%	All

Pharmacy Claims

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Col. #	Field ID	Field Name	Type	Max. Length	APCD-CDL Guidance	Notes on IN-Specific Guidance to Submitters	Threshold	Condition (Denominator)
1	CDLPC001	Data Submitter Code	Text	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi- tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLPC002).	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For the Indiana APCD, valid prefixes include: INC = Commercial carrier ING = Governmental agency INT = Third-party administrator / pharmacy benefits manager Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	All
2	CDLPC002	Placeholder	Text	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi- tiered to support different platforms).	Report as null.	0%	All
3	CDLPC003	Placeholder	Text	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	Report as null.	0%	All
4	CDLPC004	Member Insurance / Product Category Code	Text	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available.	The only valid product codes for reporting are: 19 = Prescription Drugs (Commercial Coverage) - **Requires pre-approval from IDOI** AB = Medicare Part A & B (Medicare FFS only) E = Medicare - Point of Service (POS) EP = Exclusive Provider Organization FH = Federal Employees Health Benefits Program (HMO) FP = Federal Employees Health Benefits Program (PPO) HM = Health Maintenance Organization (HMO) HN = Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C IN = Indemnity MA = Medicare Part A (Medicare FFS Only) MB = Medicare Part B (Medicare FFS Only) MC = Medicaid MD = Medicare Part D MO = Medicare Advantage PPO PR = Preferred Provider Organization (PPO) PS = Point of Service (POS) SP = Medicare Supplemental Policy	100%	All
5	CDLPC005	Payer Claim Control Number	Text	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLPC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.		100%	All
6	CDLPC006	Line Counter	Integer	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.		100%	All
7	CDLPC007	Version Number	Integer	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, Cross Reference Claims ID (CDLPC008) is to be utilized.	Use this field to report the version number of the claim service record. The version number begins with 0, and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, code as '0'.	100%	All
8	CDLPC008	Cross Reference Claims ID	Text	35	The original Payer Claim Control Number (CDLPC005). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLPC007) is not used.		0%	All
9	CDLPC009	Insured Group or Policy Number	Text	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLPC009 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	If a policy is sold to an individual as a non-group policy, report with a value of 'IND'. Medicaid and Medicare plans follow this same principle and should be reported as 'IND'.	100%	All
10	CDLPC010	Medicaid Aid Category	Text	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.		100%	Medicaid FFS only
11	CDLPC011	Subscriber Social Security Number	Text	9	Subscriber's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	Revision to field length: The value reported for this field should include only the last four digits of the subscriber's Social Security number.	95%	All
12	CDLPC012	Plan-Specific Contract Number	Text	80	Plan assigned subscriber's contract number (NCPDP refers to this as the Cardholder ID). If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid claim, provide Medicaid ID.		100%	All
13	CDLPC013	Subscriber Last Name	Text	60	The subscriber's last name.		100%	All
14	CDLPC014	Subscriber First Name	Text	35	The subscriber's first name.		100%	All
15	CDLPC015	Sequence Number	Text	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.		0%	All
16	CDLPC016	Member Social Security Number	Text	9	Member's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	Revision to field length: The value reported for this field should include only the last four digits of the member's Social Security number.	95%	All
17	CDLPC017	Individual Relationship Code	Text	2	Member's relationship to insured. Individual Relationship codes maintained by ANSI ASC X12. See Appendix H: External Code Source.	Use this field to report the member's relationship to the subscriber or the insured based on codes from the National Council for Prescription Drug Programs (NCPDP). The value reported for this field should be consistent with the value reported in the "Member Relationship" field in the eligibility file. The only valid codes for this field are: 01 = Cardholder/Self 02 = Spouse 03 = Child 04 = Other	100%	All
18	CDLPC018	Member Gender	Text	1	1 = Male; 2 = Female; 0 = Unspecified.		100%	All
19	CDLPC019	Member Date of Birth	Date	8	CCYYMMDD; Date of birth of member.		100%	All
20	CDLPC020	Member Last Name	Text	60	Member last name.		100%	All
21	CDLPC021	Member First Name	Text	35	Member first name.		100%	All
22	CDLPC022	Member ZIP Code	Text	9	Report the 5 or 9 digit Zip Code of the member's residence. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.		100%	All
23	CDLPC023	Date Prescription Filled	Date	8	CCYYMMDD. Date the prescription was filled.		100%	All

24	CDLPC024	Paid Date	Date	8	CCYYMMDD. Paid date of the claim line. Report the date that appears on the: check, and/or remit, and/or explanation of benefits, and corresponds to any and all types of payment in CCYYMMDD Format. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here.		100%	All
25	CDLPC025	National Drug Code (NDC)	Text	11	NDC Code for the drug on the claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. See Appendix H: External Code Source, United States Federal Drug Administration.		100%	All
26	CDLPC026	New Prescription or Refill	Text	2	Provide '00' for new prescriptions; for refills, provide the refill number. 00 = New prescription; 01–99 = Refill.		100%	All
27	CDLPC027	Generic Drug Indicator	Text	2	Indicates whether the drug itself is generic, not how the payer pays it. Valid codes are: 01 = Branded drug; 02 = Generic drug.		100%	All
28	CDLPC028	Dispensed as Written Code	Text	1	Use this field to indicate how the drug was dispensed: 0= No Product Selection Indicated (may also have missing values)1 = Substitution Not Allowed by Prescriber2 = Substitution Allowed - Patient Requested That Brand Product Be Dispensed3 = Substitution Allowed - Pharmacist Selected Product Dispensed4 = Substitution Allowed - Generic Drug Not in Stock 5 = Substitution Allowed - Brand Drug Dispensed as Generic6 = Override7 = Substitution Not Allowed - Brand Drug Mandated by Law8 = Substitution Allowed - Generic Drug Not Available in Marketplace9 = Other		100%	All
29	CDLPC029	Compound Drug Indicator	Text	1	Use this field to indicate whether the drug is a compound drug or non-compound drug. Valid codes are: N = Non-compound drug; Y = Compound drug; U = Unknown.		100%	All
30	CDLPC030	Drug Name	Text	128	If CDLPC029 = Y, then provide the NDC of the compound drug. If no NDC is identified, include the names of the compound drug ingredients. Use spaces between multiple drugs.	Use this field to report the text name of the drug identified by the NDC reported in CDLPC025. **Note:** Do not report NDC in this field.	100%	All
31	CDLPC031	Formulary Indicator	Text	1	Use this field to report if the prescribed drug was on the carrier's formulary list. Valid codes include: 1=Yes; 2= No; 3= Unknown; 4= Other; 5= Not applicable.		100%	All
32	CDLPC032	Quantity Dispensed	Decimal	10,2	Number of metric units of medication dispensed.	Include the decimal, with 2 digits trailing the decimal. For example, a quantity of 375.143 should be reported as '375.14.' Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -123.45).	100%	All
33	CDLPC033	Days' Supply	Integer	3	Estimated number of days the prescription will last.	Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
34	CDLPC034	Drug Unit of Measure	Text	3	Report the code that defines the unit of measure for the drug dispensed in PC033. Valid codes are EA= Each; F2= International Units; GM= Grams; ML=Milliliters; MG= Milligrams; MEQ- Milliequivalent; MM= Millimeter; UG= Microgram; UU= Unit; OT=Other.		100%	All
35	CDLPC035	Prescription Number	Text	20	Report the unique prescription identifier.		100%	All
36	CDLPC036	Charge Amount	Decimal	10,2	NCPDP refers to this as Gross Amount Due. Do not code decimal point or provide any punctuation (e.g.,$1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
37	CDLPC037	Plan Paid Amount	Decimal	10,2	NCPDP refers to this as Net Amount Due. Includes all health plan payments and excludes all member payments. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g.,$1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
38	CDLPC038	Allowed Amount	Decimal	10,2	When payment arrangement type in CDLPC049 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a prescription. When payment arrangement type in CDLPC049 is equal to 02 for fee for service, report the maximum amount contractually allowed.Report 0 if there is no allowed amount Do not code decimal point or provide any punctuation (e.g.$1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
39	CDLPC039	Sales Tax Amount	Decimal	10,2	Report the amount of state sales tax applied to this claim line. Report 0 if there is no state tax amount. Do not code decimal point or provide any punctuation (e.g.,$1,000.25 converted to 100025). Do not round up / down to whole dollars, code zero cents (00) when applicable.	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
40	CDLPC040	Ingredient Cost / List Price	Decimal	10,2	Cost of the drug dispensed. Report 0 if there is no Ingredient Cost/List Price Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
41	CDLPC041	Postage Amount Claimed	Decimal	10,2	Postage amount associated with the claim. Report 0 if there is no Postage Amount Claimed Do not code decimal point or provide any punctuation (e.g.,$1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
42	CDLPC042	Dispensing Fee	Decimal	10,2	Dispensing fee associated with the claim Report 0 if there is no Dispensing Fee. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
43	CDLPC043	Copay Amount	Decimal	10,2	Actual co-payment dollar amount paid for which the individual is responsible. (e.g., If the fixed amount is $25 but the cost to the member is $4 report, 400.) Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
44	CDLPC044	Coinsurance Amount	Decimal	10,2	The dollar amount of coinsurance for this claim line for which an individual is responsible, not the percentage. Report 0 if no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
45	CDLPC045	Deductible Amount	Decimal	10,2	The dollar amount for this claim line applied to the deductible. Report 0 if there is no deductible amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
46	CDLPC046	COB/TPL Amount	Decimal	10,2	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/ TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
47	CDLPC047	Other Insurance Paid Amount	Decimal	10,2	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report "0" if the prior payer paid 0 toward this claim line; or if there is no prior payer. Do not code decimal point or provide any punctuation (e.g.,$1,000.25 converted to 100025). May be reported as a negative.	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
48	CDLPC048	Member Self-Pay Amount	Decimal	10,2	Report the amount that the member has paid beyond the other patient obligations (e.g., gap on Medicare Part D, or difference between generic and brand) that are not otherwise listed in the file in CDLPC043, CDLPC044, CDLPC045. Report "0" if there is no member Self-Pay Amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up / down to whole dollars, code zero cents(00) when applicable.	If the value for this field is zero, report as 0, not as null. Can include negative values, with negative sign reported on the lefthand side of the value (e.g., -12345).	100%	All
49	CDLPC049	Payment Arrangement Type Flag	Text	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 07=Other.		100%	All
50	CDLPC050	Prescribing Physician ID	Text	30	Payer assigned provider ID for the prescribing physician. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.		100%	All
51	CDLPC051	Prescribing Physician NPI	Long	10	NPI number for prescribing physician.		100%	All
52	CDLPC052	Prescribing Physician First Name	Text	25	Prescribing Physician's first name or initial.		100%	All
53	CDLPC053	Prescribing Physician Last Name	Text	60	Prescribing Physician's last name.		100%	All
54	CDLPC054	Pharmacy NCPDP Number	Integer	7	Unique 7-digit number assigned by the National Council for Prescription Drug Program (NCPDP).		15%	All
55	CDLPC055	Pharmacy ID	Text	30	Payer assigned pharmacy ID. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.		100%	All
56	CDLPC056	Pharmacy Tax ID Number	Text	10	Dispensing pharmacy federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBMs may not have this data).		15%	All
57	CDLPC057	Pharmacy NPI	Long	10	NPI of the entity or individual (pharmacy) directly providing the service.		100%	All
58	CDLPC058	Pharmacy Location Street Address	Text	55	Street address of pharmacy that dispensed the prescription, including street number, name. Include suite number if applicable. Relates to CDLPC059- CDLPC061.		90%	All

59	CDLPC059	Pharmacy Location State	Text	2	State or Province where dispensing pharmacy located. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.		99%	All
60	CDLPC060	Pharmacy ZIP Code	Text	9	Report the 5 or 9-digit Zip Code of the Pharmacy. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.		100%	All
61	CDLPC061	Pharmacy Country Code	Text	2	Country where dispensing pharmacy located. Code US for United States. See Appendix H: External Code Sources, United States Postal Service		99%	All
62	CDLPC062	Mail-Order Pharmacy Indicator	Text	1	Use this field to report if the pharmacy was a mail-order pharmacy. Valid codes include: 1=Yes mail order pharmacy; 2=No-not a mail order pharmacy; 3=Unknown; 4=Other; 5=Not applicable.		100%	All
63	CDLPC063	Carrier Associated with Claim	Text	8	For each claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. See Appendix H: External Code Source, National Association of Insurance Commissioners.		0%	All
64	CDLPC064	In-Plan Network Indicator	Text	1	Use this field to specify if services from the requested provider were provided within the health plan network. Valid values are: N=No; Y=Yes; L=Leased Network.		100%	All
65	CDLPC065	Record Status Code	Text	2	Record status codes maintained by NCPDP is the code identifying type of claim. See Appendix H: External Code Source, NCPDP.	Use this field to report the status of the claim (i.e., whether paid as primary, paid as secondary, denied, etc.). The only valid codes for this field are: 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	100%	All
66	CDLPC066	Claim Line Type	Text	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment; D=Denial.		100%	All
67	CDLPC067	Reject Code	Text	3	Report the reason code for the denial. Report the code that defines the reason for denial of the claim line. If not available, leave blank. Reason codes are maintained by NCPDP. See Appendix H: External Code Source, NCPDP.		1%	Claim Line Type (CDLPC066) = 'D'
68	CDLPC068	Carrier-Specific Unique Member ID	Text	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.		100%	All
69	CDLPC069	Carrier-Specific Unique Subscriber ID	Text	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.		100%	All
70	CDLPC070	Prescriber Specialty	Text	10	Report the NUCC healthcare provider taxonomy code. See Appendix H: External Code Source, National Uniform Claim Committee.		15%	All
71	CDLPC071	Pharmacy City	Text	30	City or town where dispensing pharmacy located.		99%	All
72	CDLPCXXX	Placeholder	N/A	N/A	Reserved for future use. Elements will only be added with review from states and payers.		0%	All
73	CDLPC899	Record Type	Text	2	Value = PC.		100%	All

Provider

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Col. #	Field ID	Field Name	Type	Max. Length	APCD-CDL Guidance	Notes on IN-Specific Guidance to Submitters	Threshold	Condition (Denominator)
1	CDLPV001	Data Submitter Code	Text	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLPV002).	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For the Indiana APCD, valid prefixes include: INC = Commercial carrier ING = Governmental agency INT = Third-party administrator / pharmacy benefits manager Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	All
2	CDLPV002	Placeholder	Text	8	APCD-assigned identifier of insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	Report as null.	0%	All
3	CDLPV003	Placeholder	Text	30	CMS National Plan ID. The national plan ID is a code assigned by CMS. (PLACEHOLDER).	Report as null.	0%	All
4	CDLPV004	Payer-Assigned Provider ID for Member PCP	Text	30	Unique code identified for the provider as assigned by the reporting entity. For every provider included in the Eligibility, Medical, Pharmacy and Dental claims the payer assigned provider IDs shall be included.	This field should be reported for all providers included in the eligibility, medical, and pharmacy claim files and not just the member PCP.	100%	All
5	CDLPV005	Provider Tax ID	Text	10	Tax ID of the provider. Do not code punctuation.		90%	Entity Type Qualifier (CDLPV006) = 2
6	CDLPV006	Entity Type Qualifier	Text	1	Use this field to indicate whether the rendering provider is a person or non-person entity. 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." Valid codes are: 1=Person; 2=Non-Person Entity.		100%	All
7	CDLPV007	Provider NPI	Long	10	NPI for provider as enumerated in the Center for Medicaid and Medicare Services NPPES.		100%	All
8	CDLPV008	Provider DEA Number	Text	12	Provider Drug Enforcement Agency number. For all prescribing providers (CDLPC050) that have a DEA number.		15%	All
9	CDLPV009	Provider State License Number	Text	15	Prefix with two-character state of licensure with no punctuation. Example: COLL12345. Do not leave a blank space in between state and license number.		15%	All
10	CDLPV010	Provider First Name	Text	35	Individual first name. If provider is a facility or organization, leave blank.		100%	Entity Type Qualifier (CDLPV006) = 1
11	CDLPV011	Provider Middle Name or Initial	Text	25	Individual middle name or initial. If provider is a facility or organization, leave blank.		5%	Entity Type Qualifier (CDLPV006) = 1
12	CDLPV012	Provider Last Name or Organization Name	Text	60	Full name of provider organization or last name of individual provider.		100%	All
13	CDLPV013	Provider Suffix	Text	10	Suffix to individual name. If provider is a facility or organization, leave blank. The provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD.		0%	Entity Type Qualifier (CDLPV006) = 1
14	CDLPV014	Provider Office Street Address	Text	55	Physical address – address where the provider delivers healthcare services (street number and street name). Include suite number if applicable. Multiple addresses will require multiple provider records.		90%	All
15	CDLPV015	Provider Office City	Text	30	The city of the physical address where the provider delivers healthcare services. Multiple addresses will require multiple provider records.		99%	All
16	CDLPV016	Provider Office State	Text	2	The state of the physical address where the provider delivers healthcare services. Use postal service standard 2 letter abbreviations. Multiple addresses will require multiple provider records. See Appendix H: External Code Source, United States Postal Service.		99%	All
17	CDLPV017	Provider Office ZIP Code	Text	9	Report the 5 or 9-digit Zip Code of the Rendering Provider. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Multiple addresses will require multiple provider records. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Source.		100%	All
18	CDLPV018	Provider FIPS County Code	Text	5	Report the FIPS county code based on the provider's address. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. If member lives outside US, leave blank. See Appendix H: External Code Source, United States Census Bureau.		95%	All
19	CDLPV019	Provider Country Code	Date	2	Country code of provider's practice location. Code US for United States. See Appendix H: External Code Source, United States Postal Service.		99%	All
20	CDLPV020	Provider Phone	Text	10	Phone number of Provider.		15%	All
21	CDLPV021	Provider Specialty	Text	10	Report the NUCC healthcare provider taxonomy code. See Appendix H: External Code Source, National Uniform Claim Committee.		100%	All
22	CDLPV022	Atypical Provider Taxonomy Code	Text	10	Non-medical or atypical providers not defined as covered entities by CMS. Non-medical providers who supply non-healthcare services, such as non-emergency transportation, will continue to submit claims and other transactions using their current provider ID and taxonomy. Use Code set for Atypical Provider Taxonomy Codes (maintained by NUCC). If not applicable, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.		0%	All
23	CDLPV023	Provider Medicare Provider ID	Date	30	Provider ID as assigned by Medicare If not available, leave blank.		0%	All
24	CDLPV024	Provider Medicaid Provider ID	Text	30	Provider ID as assigned by Medicaid. If not available, leave blank.		0%	All
25	CDLPV025	Provider Specialty - 2	Text	10	Report additional NUCC healthcare provider taxonomy code for second specialty. In addition to the taxonomy code listed in CDLPV021. If not available, leave blank.See Appendix H: External Code Source, National Uniform Claim Committee.		0%	All
26	CDLPV026	Provider Specialty - 3	Text	10	Report third NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.		0%	All
27	CDLPV027	Provider Specialty - 4	Text	10	Report fourth NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.		0%	All
28	CDLPV028	Provider Specialty - 5	Text	10	Report fifth NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.		0%	All
29	CDLPVXXX	Placeholder	N/A	N/A	Reserved for future use. Elements will only be added with review from states and payers.	Report as null.	0%	All
30	CDLPV899	Record Type	Text	2	Value = PV.		100%	All

Commissions & Brokerage

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Col. #	Field ID	Field Name	Additional Notes/Description/Codes/Sources	Threshold	Condition (Denominator)
1	CB001	Data Submitter Code	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For the Indiana APCD, valid prefixes include: INC = Commercial carrier ING = Governmental agency INT = Third-party administrator / pharmacy benefits manager Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	All
2	CB002	Member Insurance / Product Category Code	The only valid product codes for reporting are: AB = Medicare Part A & B (Medicare FFS only) E = Medicare - Point of Service (POS) EP = Exclusive Provider Organization FH = Federal Employees Health Benefits Program (HMO) FP = Federal Employees Health Benefits Program (PPO) HM = Health Maintenance Organization (HMO) HN = Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C IN = Indemnity MA = Medicare Part A (Medicare FFS Only) MB = Medicare Part B (Medicare FFS Only) MC = Medicaid MD = Medicare Part D MO = Medicare Advantage PPO PR = Preferred Provider Organization (PPO) PS = Point of Service (POS) SP = Medicare Supplemental Policy	100%	All
3	CB003	Reporting Year	Use this field to report the year the commissions and brokerage fees were incurred and are being reported. For example, fees being reported for calendar year 2024 would list 2024 in this field. Only one year of fees are to be reported within a file.	100%	All
4	CB004	Direct Commission Indicator	Use this field to report the commissions/fee structure using the following codes: A - Percent of member count B - Flat fee C - Both (percent of member count and flat fee)	100%	All
5	CB005	Direct Commission - Percentage	Use this field to report compensation linked to a specific policy sold with a percentage of that policy's premium.	100%	when CDLCB003 = A or C
6	CB006	Direct Commission - Flat Fee	Use this field to report compensation linked to a specific policy sold with a fixed dollar amount per enrolled member.	100%	when CDLCB003 = B or C
7	CB007	Indirect Commission	Use this field to report compensation not tied to a single sale, but awarded for aggregate performance such as total volume, retention, persistency, or meeting carrier-defined benchmarks. Report amounts using implied decimals ($150 should be reported as 15000).	100%	All
8	CB008	Upfront Commission	Use this field to report the portion of commission paid at the time of initial policy sale or enrollment, often higher to incentivize new business. Report amounts using implied decimals ($150 should be reported as 15000).	100%	All
9	CB009	Service and Brokerage Fees	Use this field to report additional payments made to the agent/broker for administrative services or consulting, which are not tied to premium percentage or sales volume, but may be fixed fees or negotiated amounts. Report amounts using implied decimals ($150 should be reported as 15000).	100%	All
10	CB010	Percentage of Total Plan Premium	Use this field to report the commission rate as a percent of the total policy premium. For a premium which is 4.25% of the monthly premium, this field would list "4.25".	100%	All

11	CB011	Percentage of Total Plan Premium Frequency Code	Use this field to report the frequency or basis code for the percentage of Total Plan Premium using the following codes: M = Monthly A = Annual S = Semiannual Q = Quarterly F = First-year only R = Renewal For a premium which is 4% of the monthly premium, this field would list "M".	100%	All
12	CB012	Flat Member Fee	Use this field to report the fixed dollar amount paid to the agent/broker per covered member or contract, regardless of the policy premium. Report amounts using implied decimals ($150 should be reported as 15000).	100%	All
13	CB899	Record Type	Value = CB	100%	All

APCD-CDL Appendix ID	Field Name	Code	Description
G-1	Insurance Type / Product Code	11	Other Non-Federal Programs
G-1	Insurance Type / Product Code	12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
G-1	Insurance Type / Product Code	13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
G-1	Insurance Type / Product Code	14	Medicare Secondary, No-Fault Insurance including Insurance in which Auto Is Primary
G-1	Insurance Type / Product Code	15	Medicare Secondary Workers' Compensation
G-1	Insurance Type / Product Code	16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
G-1	Insurance Type / Product Code	17	Dental
G-1	Insurance Type / Product Code	18	Vision
G-1	Insurance Type / Product Code	19	Prescription Drugs (Commercial Coverage)
G-1	Insurance Type / Product Code	41	Medicare Secondary Black Lung
G-1	Insurance Type / Product Code	42	Medicare Secondary Veterans' Administration
G-1	Insurance Type / Product Code	43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
G-1	Insurance Type / Product Code	47	Medicare Secondary, Other Liability Is Primary
G-1	Insurance Type / Product Code	AM	Automobile Medical
G-1	Insurance Type / Product Code	AP	Auto Insurance Policy
G-1	Insurance Type / Product Code	BL	Blue Cross/Blue Shield
G-1	Insurance Type / Product Code	C1	Other Commercial (Not Specified Elsewhere)
G-1	Insurance Type / Product Code	CH	CHAMPUS
G-1	Insurance Type / Product Code	CI	Commercial Insurance Company
G-1	Insurance Type / Product Code	CO	Consolidated Omnibus Reconciliation Act (COBRA)
G-1	Insurance Type / Product Code	CP	Medicare Conditionally Primary
G-1	Insurance Type / Product Code	D	Disability
G-1	Insurance Type / Product Code	DB	Disability Benefits
G-1	Insurance Type / Product Code	DM	Dental Maintenance Organization
G-1	Insurance Type / Product Code	E	Medicare – Point of Service (POS)
G-1	Insurance Type / Product Code	EP	Exclusive Provider Organization
G-1	Insurance Type / Product Code	FF	Family or Friends
G-1	Insurance Type / Product Code	FH	Federal Employees Health Benefits Program (HMO)
G-1	Insurance Type / Product Code	FP	Federal Employees Health Benefits Program (PPO)
G-1	Insurance Type / Product Code	HM	Health Maintenance Organization (HMO)
G-1	Insurance Type / Product Code	HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
G-1	Insurance Type / Product Code	HS	Special Low Income Medicare Beneficiary
G-1	Insurance Type / Product Code	IN	Indemnity
G-1	Insurance Type / Product Code	IP	Individual Policy
G-1	Insurance Type / Product Code	LB	Liability
G-1	Insurance Type / Product Code	LC	Long Term Care
G-1	Insurance Type / Product Code	LD	Long Term Policy
G-1	Insurance Type / Product Code	LI	Life Insurance
G-1	Insurance Type / Product Code	LM	Liability Medical
G-1	Insurance Type / Product Code	LT	Litigation
G-1	Insurance Type / Product Code	MA	Medicare Part A (not to be used for commercial plans)
G-1	Insurance Type / Product Code	MB	Medicare Part B (not to be used for commercial plans)
G-1	Insurance Type / Product Code	MC	Medicaid
G-1	Insurance Type / Product Code	MD	Medicare Part D
G-1	Insurance Type / Product Code	MH	Medigap Part A
G-1	Insurance Type / Product Code	MI	Medigap Part B
G-1	Insurance Type / Product Code	MO	Medicare Advantage PPO
G-1	Insurance Type / Product Code	MP	Medicare Primary (not to be used for commercial plans)
G-1	Insurance Type / Product Code	MT	Medicaid CHIP
G-1	Insurance Type / Product Code	OF	Other Federal Program
G-1	Insurance Type / Product Code	OT	Other

G-1	Insurance Type / Product Code	PE	Property Insurance – Personal
G-1	Insurance Type / Product Code	PL	Personal
G-1	Insurance Type / Product Code	PP	Personal Payment (Cash – No Insurance)
G-1	Insurance Type / Product Code	PR	Preferred Provider Organization (PPO)
G-1	Insurance Type / Product Code	PS	Point of Service (POS)
G-1	Insurance Type / Product Code	QM	Qualified Medicare Beneficiary
G-1	Insurance Type / Product Code	RP	Property Insurance – Real
G-1	Insurance Type / Product Code	S1	Medicare Special Needs Plan – Chronic Condition
G-1	Insurance Type / Product Code	S2	Medicare Special Needs Plan - Institutionalized
G-1	Insurance Type / Product Code	S3	Medicare Special Needs Plan – Dual Eligible
G-1	Insurance Type / Product Code	SL	Standalone limited (for example, vision only, hearing only)
G-1	Insurance Type / Product Code	SP	Supplemental Policy
G-1	Insurance Type / Product Code	TF	Tax Equity Fiscal Responsibility Act (TEFRA)
G-1	Insurance Type / Product Code	TR	Tricare
G-1	Insurance Type / Product Code	TV	Title V
G-1	Insurance Type / Product Code	U	Multiple Options Health Plan
G-1	Insurance Type / Product Code	VA	Veterans Administration Plan
G-1	Insurance Type / Product Code	WC	Workers' Compensation
G-1	Insurance Type / Product Code	WU	Wrap Up Policy
G-1	Insurance Type / Product Code	ZZ	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)
G-2	Race 1 / Race 2 / Race 3 Codes	R1	American Indian/Alaska Native
G-2	Race 1 / Race 2 / Race 3 Codes	R2	Asian
G-2	Race 1 / Race 2 / Race 3 Codes	R3	Black/African American
G-2	Race 1 / Race 2 / Race 3 Codes	R4	Native Hawaiian or Other Pacific Islander
G-2	Race 1 / Race 2 / Race 3 Codes	R5	White
G-2	Race 1 / Race 2 / Race 3 Codes	R9	Other Race
G-2	Race 1 / Race 2 / Race 3 Codes	UN	Unknown/Not Specified
G-3	Market Category Codes	FCH	Individuals on a franchise basis
G-3	Market Category Codes	GCV	Individuals as group conversion Policies
G-3	Market Category Codes	GLG1	Employers having 51 thru 100 employees
G-3	Market Category Codes	GLG2	Employers having 101 thru 250 employees
G-3	Market Category Codes	GLG3	Employers having 251 thru 500 employees
G-3	Market Category Codes	GLG4	Employers having more than 500 employees
G-3	Market Category Codes	GS1	Employers having exactly 1 employee
G-3	Market Category Codes	GS2	Employers having 2 thru 9 employees
G-3	Market Category Codes	GS3	Employers having 10 thru 25 employees
G-3	Market Category Codes	GS4	Employers having 26 thru 50 employees
G-3	Market Category Codes	GSA	Small employers through a qualified association trust
G-3	Market Category Codes	IND	Individuals (non-group)
G-3	Market Category Codes	OTH	Other types of entities. Insurers using this market code shall obtain prior approval.

External Code Source
American Dental Association Current Dental Terminology (CDT) Codes SOURCE: Current Dental Terminology (CDT) Manual AVAILABLE FROM: American Dental Association 211 East Chicago Avenue Chicago, IL 60611-2678 ABSTRACT: The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.
American Medical Association Current Procedural Terminology (CPT) Codes SOURCE: Physicians' Current Procedural Terminology (CPT) Manual AVAILABLE FROM: American Medical Association 515 North State Street Chicago, IL 60654 ABSTRACT: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.
Accredited Standards Committee (ASC) ASC X12 Directories SOURCE: PACDR Implementation Guides, ASC X12 005010 Standard AVAILABLE FROM: Data Interchange Standards Association, Inc. (DISA) 7600 Leesburg Pike Ste 430 Falls Church, VA 22043 http://store.x12.org/store Washington Publishing Company http://www.wpc-edi.com/reference/ ABSTRACT: The PACDR Implementation Guides contain the descriptions of data elements used to construct X12 segments. The PACDR Guides also contain code lists associated with these data elements.
Centers for Disease Control and Prevention SOURCE: Race and Ethnicity Code Set AVAILABLE FROM: Centers for Disease Control and Prevention 1600 Clifton Road Atlanta, GA 30329-4027 FILE: 2022_RaceAndEthnicityFinal_TablesforPub_Final.xlsx - Race and Ethnicity Download File (Full Code System, relationships, and Hierarchy codes) found in "CDC Race Category and Ethnicity Group" at https://phinvads.cdc.gov/vads/SearchVocab.action. ABSTRACT: The race and ethnicity code set is used for coding the race and ethnicity of the member.
Centers for Medicare and Medicaid Services Health Care Common Procedural Coding System SOURCE: Health Care Common Procedural Coding System AVAILABLE FROM: Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244-1850 www.cms.gov/HCPCSReleaseCodeSets/ ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

Centers for Medicare and Medicaid Services
Health Insurance Prospective Payment System (HIPPS)
SOURCE: Center for Medicare & Medicaid Services
AVAILABLE FROM:
Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
http://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
ABSTRACT: Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. For the payment systems that use HIPPS codes, clinical assessment data is the basic input used to determine which case-mix group applies to a particular patient. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group. For payment purposes, at least one HIPPS code is defined to represent each case-mix group. These HIPPS codes are reported on claims to insurers.

Centers for Medicare and Medicaid Services
HHS Actuarial Value Calculator
SOURCE: Center for Consumer Information & Insurance Oversight
AVAILABLE FROM:
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html
ABSTRACT: CCIIO publishes an AV calculator on an annual basis.

Centers for Medicare and Medicaid Services
National Provider Identifier
SOURCE: National Plan and Provider Enumeration System
AVAILABLE FROM:
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
https://nppes.cms.hhs.gov/NPPES/Welcome.do
ABSTRACT: The Centers for Medicare and Medicaid Services developed the National Provider Identifier as the standard, unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

Centers for Medicare and Medicaid Services
Place of Service Codes for Professional Claims
SOURCE: Place of Service Codes for Professional Claims
AVAILABLE FROM:
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf
ABSTRACT: The place of service code identifies the location where the healthcare service was rendered.

ISO 3166 Maintenance Agency
Country Codes
SOURCE: ISO 3166 Maintenance Agency
AVAILABLE FROM:
ISO 3166 Maintenance Agency
c/o International Organization for Standardization Chemin de Blandonnet 8
CP 401
1214 Vernier, Geneva Switzerland
Telephone: +41 22 749 01 11
e-mail: customerservice@iso.org www.iso.org/iso/country_codes

ISO 639-3:2007 Language
Language
SOURCE: ISO 639 Maintenance Agency
AVAILABLE FROM:
International Organization for Standardization ISO Central Secretariat
Chemin de Blandonnet 8 CP 401
1214 Vernier, Geneva, Switzerland
E-mail: central@iso.org
https://www.iso.org/standard/39534.html

National Association of Insurance Commissioners
NAIC Codes
SOURCE: National Association of Insurance Commissioners
AVAILABLE FROM:
NAIC Central Office
1100 Walnut Street Suite 1500
Kansas City, MO 64106
816-842-3600
http://www.naic.org/prod_serv/LOC-ZU-15-01.pdf, https://eapps.naic.org/cis/companySearch.do
ABSTRACT: NAIC maintains an identification code for each payer that is a 5-digit unique number assigned to an insurance entity by the NAIC. NAIC has developed a tool to look up the code and find the company, or look up the company to find the code:

National Council for Prescription Drug Programs (NCPDP)
National Association of Boards of Pharmacy Number
SOURCE: National Association of Boards of Pharmacy Database and Listings
AVAILABLE FROM:
www.ncpdp.org
National Council for Prescription Drug Programs
9240 East Raintree Drive
Scottsdale, AZ 85260-7518
ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy Number is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

National Council for Prescription Drug Programs (NCPDP) Uniform Healthcare Payer Data SOURCE: NCPDP Uniform Healthcare Payer Data Standard Implementation Guide AVAILABLE FROM: National Council for Prescription Drug Programs 9240 East Raintree Drive Scottsdale, AZ 85260 www.ncpdp.org ABSTRACT: The Implementation Guide is intended to meet an industry need to supply detailed drug or utilization claim information from adjudicated claims that processors/payers or their clients report to States or their Agents.
National Uniform Billing Committee (NUBC) NUBC Codes SOURCE: National Uniform Billing Committee Official Data Specifications Manual AVAILABLE FROM: National Uniform Billing Committee American Hospital Association 155 N Wacker Drive Chicago, IL 60606 www.nubc.org
National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Code Set SOURCE: Washington Publishing Company AVAILABLE FROM: National Uniform Claim Committee nuccinfo@nucc.org http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40
United States Food and Drug Administration (FDA) National Drug Codes SOURCE: National Drug Data File AVAILABLE FROM: U.S. Food and Drug Administration Center for Drug Evaluation and Research Division of Data Management and Services 10903 New Hampshire Avenue Silver Spring, MD 20993 www.fda.gov or http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm
United States Census Bureau 2010 FIPS Codes for Counties and County Equivalent Entities SOURCE: United States Census Bureau, Geography https://www.census.gov/library/reference/code-lists/ansi.html AVAILABLE FROM: United States Census Bureau, Geography https://www.census.gov/geo/reference/codes/cou.html

United States Postal Service (USPS)
States and Outlying Areas of the U.S. ZIP Code
SOURCE: United States Postal Service
AVAILABLE FROM:
U.S. Postal Service
National Information Data Center
P.O. Box 9408
Gaithersburg, MD 20898-9408
https://www.usps.com
ABSTRACT: Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two right-most digits identify a local delivery area. In the 9-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

World Health Organization (WHO)
International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure and Diagnosis
SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
AVAILABLE FROM:
WHO Publications Center AUS
49 Sheridan Avenue
Albany, NY 12210
http://www.cdc.gov/nchs/icd/icd9cm.htm
ABSTRACT: The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and procedures.

World Health Organization (WHO)
International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)
SOURCE: International Classification of Diseases, 10th Revision, (ICD-10-CM/PCS)
AVAILABLE FROM:
WHO Publications Center AUS
49 Sheridan Avenue
Albany, NY 12210
www.cdc.gov/nchs/icd/icd10cm.htm#9update
ABSTRACT: The International Classification of Diseases, 10th Revision, is used to report medical diagnosis in all U.S. health care settings after October 1, 2015.