Attachment 1
MEDICAL CLAIM FIELD REQUIREMENTS

Field #	Field Name	Field Description
1	Group Number	Unique identifier for the group.
2	Group Name	Name of the group.
3	Member/Subscriber Number	Unique identifier of the Member/Subscriber.
4	Patient Identifier	Unique identifier of the patient within the Member Number.
5	Patient Date of Birth	Patient age as of date of service or complete date of birth.
6	Patient Gender	F=Female; M=Male
7	Claim Number	The unique number assigned to this claim by the plan.
8	Claim/Charge Line #	The line number assigned to this charge. If the claim only has one charge line, the value will usually be 1.
9	Claim Type	Indicates the type of claim being reported (i.e. I = Inpatient Hospital, O = Outpatient Hospital, P = Physician, etc.)
10	First Date of Service	The first billed date/incurred date of service for the charge.
11	Last Date of Service	The last date of service/discharge date for the charge.
12	Number of Services/Days	The number of times the same service, etc. was rendered.
13	Service Units Code	Identifies the unit of measurement for the Number of Services field (i.e. DA = Days; DH = Ambulance Miles; MA = Therapeutic Dosage Amount; MJ = Minutes; UN = Units; VS = Visits; etc.)
14	Place of Service Code	Code identifies where the services were rendered (i.e. inpatient hospital, outpatient hospital, ambulatory surgical center, physician's office, patient's home, ambulance, etc.)
15	Type of Service Code	Code indicates the type of service rendered (i.e. surgery, anesthesia, diagnostic radiology, diagnostic pathology, physical therapy, speech therapy, home health care, etc.)
16	Diagnosis Code	The primary diagnosis for the charges on this line. Use ICD-9 or equivalent code.
17	Procedure Code	The primary procedure performed by the provider for the charges on this line. Use CPT-4 or HCPCS codes for professional claims, ADA codes for dental claims, ICD-9 procedure codes or revenue codes for facility claims, etc.
18	Procedure Modifier Code	Code indicates additional information about the procedure (i.e. a specific body part, who performed the procedure, etc.)
19	Performing Provider ID	ID assigned to the performing provider for the service. The Federal Tax ID Number (FTIN), National Provider ID (NPI) or other ID used by the plan.
20	Performing Provider Name	Name of the Performing Provider (Last Name as a minimum).
21	Performing Provider Zip Code	Zip code of the provider who performed the service or rendered the care.
22	Performing Provider Specialty Code	Code identifies the specialty of the Performing Provider.

23	Performing Provider Network Status	Code to indicate whether the performing provider is in the network (Y), out of the network (N), etc.
24	Date Paid	Date the plan paid the claim.
25	Payee	Code to indicate the recipient of the insurance payment. P = Provider; S = Subscriber; T = 3rd party
26	Billed Charges Amount	Total amount charged by the performing provider for the service.
27	Allowed/Covered Amount	The amount of the billed charges are covered by the plan.
28	Other Carrier Coverage Code	Code to indicate which, if any, other insurance has primary liability. Field is blank if this insurance is primary.
29	Medicare Payment Disposition Code	Code to indicate if patient is enrolled in Medicare and which part of Medicare was primary. Field is blank if this insurance is primary.
30	Amount Paid by Other Insurance	Amount paid by another insurance for this service.
31	Pricing Method Code	C = Encounter/Capitated Service; D = Per Diem; G = Diagnostic Related Grouping (DRG); M = Maximum Allowable Charge (MAC); P = Percentage; U = Usual, Customary & Reasonable (UCR); etc.
32	Patient Liability Amount	The patient's out-of-pocket expense for this charge. It is comprised of the remaining calendar year deductible amount, copayment amount and coinsurance amount, depending on the plan's benefit structure for the service.
33	Insurance Amount Paid	The amount paid to the payee by this insurance company for the service on this line.