MMSEA Section 111
MSP Mandatory Reporting

Interim Record Layout Information for:

- **Liability Insurance (Including Self-Insurance)**
- **No-Fault Insurance**
- **Workers' Compensation**

The complete Section 111 User Guide for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation is in process.

MMSEA Section 111 Mandatory Reporting - Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation

Overview

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), adds new Medicare Secondary Payer (MSP) mandatory reporting requirements for group health plan (GHP) arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation (sometimes collectively referred to as Non-Group Health Plan, Non-GHP or NGHP).

This document provides information on the file layouts that will be used by entities responsible for complying with the reporting requirements at 42 U.S.C. 1395y(b)(8) for liability insurance (including self-insurance), no-fault insurance, and workers' compensation You must use the applicable statutory language *in conjunction with* "Attachment A – Definitions and Reporting Responsibilities" to the Supporting Statement for the Paperwork Reduction Act (PRA) Notice published in the Federal Register on August 1, 2008 in order to determine if you are a "responsible reporting entity" or "RRE" for purposes of these new provisions. The statutory language, the PRA Notice and the PRA Supporting Statement with Attachments are all available as downloads at www.cms.hhs.gov/MandatoryInsRep. "Attachment A" to the Supporting Statement provides details on definitions and exactly which entities must report.

Complete instructions and requirements will be published at a later date in the MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide, and this user guide will be available as a download on the dedicated Section 111 Web page at www.cms.hhs.gov/MandatoryInsRep when completed. RREs are encouraged to visit this site often for updates on Section 111 reporting requirements.

The purpose of the Section 111 MSP reporting process is to enable CMS to correctly pay for Medicare covered items and services furnished to Medicare beneficiaries by determining primary versus secondary payer responsibility. Section 111 requires RREs to submit information specified by the Secretary in a form and manner (including frequency) specified by the Secretary. The Secretary requires data for both claims processing and for MSP recovery actions, where applicable. RREs will submit information electronically on liability insurance (including self-insurance), no-fault insurance, and workers' compensation claims where the injured party is a Medicare beneficiary. The actual data submission process will take place between the RREs and the CMS Coordination of Benefits Contractor (the COBC). The COBC will manage the technical aspects of the Section 111 data submission process for all Section 111 RREs.

Note: For purposes of RRE submissions, the term "claim" is used to refer to the claim for liability insurance (including self-insurance), no-fault insurance or workers' compensation rather than a single claim for a particular medical item or service.

Section 111 RREs are required to register with the COBC and fully test the data submission process before submitting production files. RREs will then be assigned a quarterly file submission timeframe during which they are to submit files. Once in a production mode, RREs will submit their initial files containing information for all liability insurance (including self-insurance), no-fault insurance, and workers' compensation claims involving a Medicare beneficiary as the injured party where the settlement, judgment, award or other payment date is July 1, 2009 or subsequent and claims on which ongoing responsibility for medical payments exists as of July 1, 2009, regardless of the date of an initial acceptance of payment responsibility. Subsequent quarterly file submissions are to contain only new or changed claim information using add, delete and update transactions.

The data necessary for the Section 111 NGHP reporting process is documented in the attached record layouts. An RRE electronically transmits a data file to the COBC. The COBC processes the data in this *input file* by first editing the incoming data. Other insurance information for Medicare beneficiaries derived from the input file is posted on the Medicare Common Working File (CWF) by the COBC for use by other Medicare contractors for claims processing and/or passed to the CMS Medicare Secondary Payer Recovery Contractor (MSPRC) for recovery efforts. When this processing is completed or the prescribed time for response file generation has elapsed, the COBC electronically transmits a *response file* back to the RRE. The response file will include information on any errors found, disposition codes that indicate the results of processing, and MSP information as prescribed by the response file format.

Who Must Report

Section 111 defines a responsible reporting entity (RRE) to be an applicable plan:

"APPLICABLE PLAN- In this paragraph, the term `applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:
(i) Liability insurance (including self-insurance).
(ii) No fault insurance.
(iii) Workers' compensation laws or plans."

As stated, you must use the applicable statutory language *in conjunction with* "Attachment A – Definitions and Reporting Responsibilities" to the Supporting Statement for the Paperwork Reduction Act (PRA) Notice published in the Federal Register on August 1, 2008, in order to determine if you are a "responsible reporting entity" or "RRE" for purposes of these new provisions. The statutory language, the PRA Notice and the PRA Supporting Statement with Attachments are all available as downloads at www.cms.hhs.gov/MandatoryInsRep. "Attachment A" to the Supporting Statement provides details on definitions and exactly which entities must report.

An RRE may contract with an entity to act as its agent for purposes of the Section 111 data submission process. Agents may include, but are not limited to data service companies, consulting companies or similar entities that can create and submit Section 111 files to the COBC on behalf of the RRE. If an RRE contracts with an agent for purposes of the Section 111 process, the RRE must supply information regarding its agent as part of the Section 111 registration process. An agent is **not** an RRE. The RRE remains solely responsible and accountable for complying with CMS instructions for implementing Section 111 and for the accuracy of data submitted. See also the discussion of "agents" in the previously referenced "Attachment A – Definitions and Reporting Responsibilities" document.

General Requirements

- Input Claim Files must include properly formatted header, detail and trailer records as defined in the file layouts provided.
- Input Claim Files must be submitted on a quarterly basis, four times a year.
- Files must be submitted within an assigned, 7-day submission period each quarter. File submission timeframes will be assigned after successful registration for Section 111 reporting.
- RREs will be assigned a Section 111 Reporter ID during registration which is to be used on all submitted files.
- Section 111 liability insurance (including self-insurance), no-fault insurance, and workers' compensation RREs must submit their initial production Section 111 Input Claim File during the fourth calendar quarter (October - December) of 2009 during their assigned submission timeframe.

- RREs must register on the COB Secure Web site (COBSW) by June 30, 2009, and complete testing prior to submission of production files. (The earliest date for registration is May 1, 2009.)
- Files may be submitted via the COBSW using Hypertext Transfer Protocol over Secure Socket Layer (HTTPS) or Secure File Transfer Protocol (SFTP). As an alternative, RREs with large amounts of data may submit via Connect:Direct (formerly known as NDM) via the AT&T Global Network System (AGNS). To use the AGNS method, RREs must first establish an AGNS account in order to send files directly to the COBC over AGNS. RREs that currently do not have an existing AGNS account should contact one of the well-established resellers of AT&T services to obtain a dedicated or a dial-up access line to the AGNS VAN. ***RREs are encouraged to do this as soon as possible since this set up can take a significant amount of time.***
- RREs must implement a procedure in their claims resolution process to determine whether an injured party is a Medicare beneficiary. RREs must submit either the Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN) for the injured party on all Input Claim File detail records.
- RREs' initial file submissions must report on all claims, where the injured party is/was a Medicare beneficiary, that are resolved (or partially resolved) through a settlement, judgment, award or other payment on or after July 1, 2009, regardless of the assigned date for a particular RREs first submission. This includes resolution (or partial resolution) through one payment obligation (regardless of whether the payment obligation is executed through a single payment, a structured settlement, or an annuity) as well as those situations where there is a responsibility for ongoing medical services.
- RREs must also report on claims for which the RRE still has responsibility for ongoing payments for medical services as of July 1, 2009, regardless of an initial resolution (partial resolution) date prior to July 1, 2009). (See the associated special reporting extension later in this document.)
- If an RRE has accepted Ongoing Responsibility for Medical payments (ORM) on a claim, then the RRE must report two events; an initial record to reflect the acceptance of ongoing payment responsibility and a second (final) record to reflect the end date of ongoing payment responsibility with the corresponding end date reflected in the ORM Termination Date (Field 78). Because reporting is done only on a quarterly basis, there may be some situations in which the RRE reports the assumption of ongoing responsibility in the same record as which a termination date for such responsibility. RREs are **not** to submit a report on the Input Claim File every time a payment is made for situations involving ongoing payment responsibility.
- A Federal Tax Identification Number (TIN) Reference File must be submitted with the Initial Claim File containing records for each plan TIN submitted in Field 47 of Claim File detail records. For those who are self-insured, their TIN may be an Employer Identification Number (EIN) or Social Security Number (SSN) depending upon their particular situation.
- All combinations of Plan TIN and TIN Site ID submitted in Fields 47 and 48 of the Claim File detail records must have a corresponding TIN/TIN Site ID combination on the TIN Reference File.
- Subsequent Claim Files do not need to be accompanied by a TIN Reference File unless changes to previously submitted TIN/Site ID information or new TIN/TIN Site ID combinations have been added.

- Subsequent quarterly update files must include records for any new claims, where the injured party is a Medicare beneficiary, reflecting settlement, judgment, award, or other payment since the last file submission. However, if the settlement, judgment, award or other payment is within 45 days prior to the start of the 7-day file submission timeframe, then an RRE may submit that claim on the next quarterly file. This grace period allows the RRE time to process the newly resolved (partially resolved) claim information internally prior to submission for Section 111. For example, if the settlement date is May 1, 2010, and the file submission period for the second calendar quarter of 2010 is June 1-7, 2010, then the RRE may delay reporting that claim until the third calendar quarter file submission during September 1-7, 2010. However, if the settlement date is April 1, 2010, then the RRE must include this claim on the second calendar quarter file submission during June 1-7, 2010. Records not received timely will be processed but marked as late and used for subsequent compliance tracking.
- Subsequent quarterly update files must include pertinent updates/corrections/deletions to any previously submitted records.
- Quarterly update files must contain resubmission of any records found in error on the previous file with corrections made. No interim file submissions will be accepted.
- If you have no new information to supply on a quarterly update file, you must submit an “empty” Claim Input File with a header record, no detail records, and a trailer record that indicates a zero detail record count.
- E-mail notifications will be sent to the Section 111 RRE contacts after a file has been initially processed and when a response file has been transmitted or is available for download.
- Each detail record on the Input Claim File must contain a unique Document Control Number (DCN) generated by the RRE. This DCN is required so that response records can be matched and issues with files more easily identified and resolved. It can be any format of the RREs choosing as long as it is not more than 10 alpha-numeric characters as defined in the record layout. Most of CMS’ current data exchange partners use some form of a Julian date and a counter as their DCN.
- The COBC will return response files to the RRE within 45 days of the receipt date posted for the input file.

Special Reporting Extension for Ongoing Claims Resolved (Partially Resolved) Prior to July 1, 2009

The CMS recognizes that Section 111 RREs for liability insurance (including self-insurance), no-fault insurance, and workers' compensation may not currently carry the Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN) for injured parties or track whether they are Medicare beneficiaries in their systems. The CMS is providing a limited extension through June 30, 2010 to these RREs until 06/30/10, to deal with situations where information required for Section 111 reporting on pre-existing situations is not available. The extension is intended to allow RREs time to go back and determine the Medicare status of individuals for whom there is pre-existing ongoing payment responsibility which continues as of July 1, 2009.
From October 1, 2009 through June 30, 2010, RREs must report on claims with resolution (partial resolution) dates of July 1, 2009, and subsequent – for both ongoing responsibility cases and one-time payment cases. The extension does *not* apply to claims with resolution (partial resolution) dates of July 1, 2009, and subsequent. The extension applies only to claims where the RRE has accepted ongoing responsibility, with the claim potentially subject to further payment as of 7/1/09, but the original resolution (partial resolution) date is prior to 7/1/09. If an RRE has the information that such a claimant is a Medicare beneficiary and the RRE has the SSN or HICN, it is to send the record with its initial file in fourth calendar quarter 2009. If they do not have this information, they may delay reporting on these claims until their third calendar quarter 2010 file submission.

MMSEA Section 111 Mandatory Reporting - Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation

Input Claim File Layout

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Input Claim File Header Record – 1800 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGCH'. **Required.**
2	Section 111 Reporter ID	9	5	13	Numeric	COBC assigned Section 111Reporter ID #. **Required.**
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Must be 'NGHPCLM'. **Required.**
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the COBC. Format: CCYYMMDD **Required.**
5	Filler	1772	29	1800	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Input Claim File Detail Record – 1800 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
Injured Party/Medicare Beneficiary Information (The injured party is/was a Medicare beneficiary.)						
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGCD'. **Required.**
2	DCN	10	5	14	Alpha-numeric	Document Control Number; assigned by the Section 111 RRE. Each record shall have a unique DCN. DCN will be supplied back by COBC on corresponding response file records for tracking purposes. **Required.**
3	Action Type	1	15	15	Numeric	Action to be performed. Valid values: 0 = Add 1 = Change/Update 2 = Delete **Required.**
4	Injured Party HICN	12	16	27	Alpha-numeric	Medicare Health Insurance Claim Number Fill with spaces if unknown. **Required if SSN not provided.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
5	Injured Party SSN	9	28	36	Numeric	Social Security Number Fill with 999999999 if unknown. **Required if HICN not provided.**
6	Injured Party Last Name	25	37	61	Alpha-betic	Surname of Injured Party **Required.**
7	Injured Party First Name	15	62	76	Alpha-betic	Given or first name of Injured Party. **Required.**
8	Injured Party Middle Init	1	77	77	Alpha-betic	First letter of Injured Party middle name. Fill with space if unknown.
9	Injured Party Gender	1	78	78	Numeric	Code to reflect the sex of the injured party. Valid values: 1 = Male 2 = Female Default to 1, if unknown. **Required.**
10	Injured Party DOB	8	79	86	Numeric Date	Date of Birth of Injured Party Format: CCYYMMDD **Required.**
11	Reserved for Future	20	87	106	Alpha-numeric	Fill with spaces.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
***Injury/Incident/Illness* Information**						
12	Date of Incident (DOI)	8	107	114	Numeric Date	Date of Incident (DOI): For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the date of first exposure. For claims involving ingestion (for example, a recalled drug), it is the date of first ingestion. For claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants). Format: CCYYMMDD **Required.**
13	Nature of Injury, Incident, Illness	2	115	116	Numeric	Workers' Compensation Insurance Organization (WCIO) Nature of Injury Code. Report the 2-digit code that corresponds to the nature of the injury sustained by the injured party/claimant. Required for all claim types including Liability, No-Fault, and Workers' Compensation. Refer to https://www.iisprojects.com/WCIO/pub/PNC/WCIO_Nature_Table.pdf. **Required.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
14	Filler	2	117	118	Alpha-numeric	Future expansion. Fill with spaces.
15	Cause of Injury, Incident, or Illness	2	119	120	Numeric	Workers' Compensation Insurance Organization (WCIO) Cause of Injury Code. Report the 2-digit code that corresponds to the cause of the injury. Required for all claim types including Liability, No-Fault, and Workers' Compensation. Refer to https://www.iisprojects.com/WCIO/pub/PNC/WCIO_Cause_Table.pdf. **Required.**
16	Filler	2	121	122	Alpha-numeric	Future expansion. Fill with spaces.
17	State of Venue	2	123	124	Alpha-betic	US postal abbreviation corresponding to the US State whose state law controls resolution of the claim. Insert "US" where the claim is a Federal Tort Claims Act liability insurance matter or a Federal workers' compensation claim. **Required.**
18	Filler	1	125	125	Alpha-numeric	Future expansion. Fill with spaces.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
19	ICD-9 Diagnosis Code 1	5	126	130	Alpha-numeric	ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) Diagnosis Code describing the injury/illness. Refer to http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf and http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm. At least one ICD-9 Diagnosis Code or Body Part Code is required. **Required if no Body Part 1 Code is provided.**
20	Filler	3	131	133	Alpha-numeric	Future expansion. Fill with spaces.
21	ICD-9 Diagnosis Code 2	5	134	138	Alpha-numeric	See explanation for Field 19. Provide if available/applicable.
22	Filler	3	139	141	Alpha-numeric	Future expansion. Fill with spaces.
23	ICD-9 Diagnosis Code 3	5	142	146	Alpha-numeric	See explanation for Field 19. Provide if available/applicable.
24	Filler	3	147	149	Alpha-numeric	Future expansion. Fill with spaces.
25	ICD-9 Diagnosis Code 4	5	150	154	Alpha-numeric	See explanation for Field 19. Provide if available/applicable.
26	Filler	3	155	157	Alpha-numeric	Future expansion. Fill with spaces.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
27	ICD-9 Diagnosis Code 5	5	158	162	Alpha-numeric	See explanation for Field 19. Provide if available/applicable.
28	Filler	2	163	164	Alpha-numeric	Future expansion. Fill with spaces.
29	Body Part Code 1	3	165	167	Alpha-numeric	Code corresponding to the part of the body injured. Refer to https://www.iisprojects.com/WCIO/pub/PNC/WCIO_Part_Table.pdf. At least one ICD-9 Diagnosis Code or Body Part Code is required. See explanation for Field 19. **Required if no ICD-9 Diagnosis Code 1 provided.**
30	Body Part Code 2	3	168	170	Alpha-numeric	Code corresponding to the part of the body injured. Refer to https://www.iisprojects.com/WCIO/pub/PNC/WCIO_Part_Table.pdf. Provide if available/applicable.
31	Body Part Code 3	3	171	173	Alpha-numeric	Code corresponding to the part of the body injured. Refer to https://www.iisprojects.com/WCIO/pub/PNC/WCIO_Part_Table.pdf. Provide if available/applicable.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
32	Body Part Code 4	3	174	176	Alpha-numeric	Code corresponding to the part of the body injured. Refer to https://www.iisprojects.com/WCIO/pub/PNC/WCIO_Part_Table.pdf. Provide if available/applicable.
33	Body Part Code 5	3	177	179	Alpha-numeric	Code corresponding to the part of the body injured. Refer to https://www.iisprojects.com/WCIO/pub/PNC/WCIO_Part_Table.pdf. Provide if available/applicable.
34	Product Liability Indicator	1	180	180	Alpha-numeric	Indicates whether injury, illness or incident was allegedly caused by/contributed to by a particular product. Some product liability situations involve a product which allegedly results in situations involving falls or other accidents. Others may involve exposure to, implantation of, or ingestion of a particular product. Valid values: Y = Yes N = No ***Required.***

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
35	Product Generic Name	40	181	220	Alpha-numeric	Generic name of product alleged to be cause of injury, illness or incident. If no generic name applicable, supply brand name. **Required if Product Liability Indicator is Yes.**
36	Product Brand Name	40	221	260	Alpha-numeric	Brand name of product alleged to be cause of injury, illness or incident. **Required if Product Liability Indicator is Yes.**
37	Product Manufacturer	40	261	300	Alpha-numeric	Maker of product named above. **Required if Product Liability Indicator is Yes.**
38	Product Alleged Harm	255	301	555	Alpha-numeric	Free-form description of harm allegedly caused by product named above. **Required if Product Liability Indicator is Yes.**
Policyholder Information						
39	Policyholder Type	1	556	556	Alpha-numeric	Identifies whether policyholder is an organization or individual. Valid values: I = Individual O = Other than Individual (e.g. Business, corporation, organization, company, etc.) ***Required.***

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
40	Policyholder Last Name	25	557	581	Alpha-betic	Surname of policyholder. **Required if Policy Type = I.**
41	Policyholder First Name	15	582	596	Alpha-betic	Given/First name of policyholder. **Required if Policy Type = I.**
42	DBA Name	40	597	636	Alpha-numeric	"Doing Business As" Name of organization/business policyholder. **Required if Policy Type = O.**
43	Legal Name	40	637	676	Alpha-numeric	Legal Name of organization/business policyholder. **Required if Policy Type = O.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
44	Self Insured Indicator	1	677	677	Alpha-numeric	Indication of whether policyholder is self-insured or not. Valid values: Y = Yes N = No For a definition of self-insurance, refer to Attachment A – Definitions and Reporting Responsibilities of the Supporting Statement for the Medicare Secondary Payer Mandatory Insurer Reporting Requirements of Section 111 of the MMSEA of 2007 (CMS-10265) at https://www.cms.hhs.gov/MandatoryInsRep/Downloads/SupportingStatement082808.pdf. ***Required if Plan Insurance Type is E or L (Workers' Compensation or Liability).***
45	Reserved for Future Use	10	678	687	Alpha-numeric	Fill with spaces.
Plan Information						
46	Plan Insurance Type	1	688	688	Alpha-numeric	Type of insurance coverage or line of business provided by the plan policy or self-insurance. Valid values: D = No-Fault E = Workers' Compensation L = Liability ***Required.***

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
47	TIN	9	689	697	Numeric	Federal Tax Identification Number of the "applicable plan," whether liability insurance (including self-insurance), no-fault insurance or a workers' compensation law or plan. Must have a corresponding entry with associated TIN Site ID on the TIN Reference File. ***Required.***
48	TIN Site ID	3	698	700	Numeric	3 digit identifier to uniquely identify variations in insurer addresses/claim offices/Plan Contact Address. Defined by RRE. Used to uniquely specify different addresses associated with one TIN. If only one address will be used per reported TIN, fill with zeroes. Must have a corresponding entry with associated TIN on the TIN Reference File. A record must be submitted on the TIN Reference File for each unique TIN/Site ID combination. ***Required.***
49	Policy Number	20	701	720	Alpha-numeric	The unique identifier for the policy under which the underlying claim was filed. RRE defined. ***Required.***

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
50	Claim Number	30	721	750	Alpha-numeric	The unique claim identifier by which the primary plan identifies the claim. ***Required.***
51	Plan Contact Department Name	20	751	770	Alpha-numeric	Name of department for the Plan Contact to which claim-related communication and correspondence should be sent. ***Required.***
52	Plan Contact Last Name	25	771	795	Alpha-numeric	Surname of individual that should be contacted at the Plan for claim-related communication and correspondence. ***Required.***
53	Plan Contact First Name	15	796	810	Alpha-numeric	Given or first name of individual that should be contacted at the Plan for claim-related communication and correspondence. ***Required.***
54	Plan Contact Phone	10	811	820	Numeric	Telephone number of individual that should be contacted at the Plan for claim-related communication. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). ***Required.***

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
55	Plan Contact Phone Extension	5	821	825	Alpha-numeric	Telephone extension number of individual that should be contacted at the Plan for claim-related communication. Fill with all spaces if unknown or not applicable.
56	Filler	60	826	885	Alpha-numeric	Future Expansion Fill with spaces.
57	No-Fault Insurance Arrangement Indicator	1	886	886	Alpha-numeric	Valid values: 1 = The arrangement is a stand alone or independent no-fault insurance policy. 2 = The no-fault arrangement is associated with a liability insurance policy. Space = not applicable (no-fault coverage not a part of policy coverage). **Required.**
58	Total No-Fault Insurance Limit	11	887	897	Numeric	Total dollar amount of limit on no-fault insurance arrangement. *S*pecify dollars and cents with implied decimal. No formatting (no $ or , or .) For example, a limit of $10,500.00 should be coded as 00001050000. Fill with all zeroes if not applicable. **Required if No-Fault Insurance Arrangement Indicator (Field 57) is 1 or 2.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
59	Specified Medicals Cap Amount In a Stand Alone or Independent No-Fault Insurance Policy	11	898	908	Numeric	Dollar amount of cap specified on medicals for a stand alone or independent no-fault insurance policy. Specify dollars and cents with implied decimal. No formatting (no $ or , or .) For example, a limit of $10,500.00 should be coded as 00001050000. Fill with all zeroes if not applicable. **Required if No-Fault Insurance Arrangement Indicator (Field 57) is 1.**
60	Exhaust Date for Total Amount for No-Fault Insurance	8	909	916	Numeric Date	Date on which limit was reached or benefits exhausted for Total No-Fault Insurance Limit (Field 58). Format: CCYYMMDD Fill with zeros if not applicable. **Required if No-Fault Insurance Arrangement Indicator (Field 57) is 1 or 2 and benefit limit reached.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
61	Exhaust Date for Specified Medicals Cap Amount in a Stand Alone or Independent No-Fault Insurance Policy	8	917	924	Numeric Date	Date on which limit was reached or benefits exhausted for Specified Medicals Cap Amount In a Stand Alone or Independent No-Fault Insurance Policy (Field 59). Format: CCYYMMDD Fill with zeros if not applicable. **Required if No-Fault Insurance Arrangement Indicator (Field 57) is 1 and benefit limit reached.**
62	Reserved for Future Use	30	925	954	Alpha-numeric	Fill with spaces
Injured Party's Attorney or Other Representative Information						
Attorney/Representative information required only if injured party has a representative.						
63	Injured Party Representative Indicator	1	955	955	Alpha-numeric	Code indicating the type of Attorney/Other Representative information provided. Valid values: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Space = None **Required if Injured Party has a representative.**
64	Representative Last Name	25	956	980	Alpha-betic	Surname of representative. **Required if Injured Party has a representative.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
65	Representative First Name	15	981	995	Alpha-betic	Given or first name of representative. **Required if Injured Party has a representative.**
66	Representative Firm Name	40	996	1035	Alpha-numeric	Representative's firm name. **Required if Representative is associated with a firm.**
67	Representative TIN	9	1036	1044	Numeric	Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN). **Required.**
68	Representative Mailing Address Line 1	40	1045	1084	Alpha-numeric	First line of the mailing address for the representative named above. **Required if Injured Party has a representative.**
69	Representative Mailing Address Line 2	40	1085	1124	Alpha-numeric	Second line of the mailing address of the representative named above.
70	Representative City	30	1125	1154	Alpha-numeric	Mailing address city for the representative named above. **Required if Injured Party has a representative.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
71	Representative State	2	1155	1156	Alpha-numeric	US Postal abbreviation state code for the representative named above. **Required if Injured Party has a representative.**
72	Representative Mail Zip Code	5	1157	1161	Numeric	5-digit Zip Code for the representative named above. **Required if Injured Party has a representative.**
73	Representative Mail Zip+4	4	1162	1165	Numeric	4-digit Zip+4 code for the representative named above. If not applicable or unknown, fill with zeroes (0000).
74	Representative Phone	10	1166	1175	Numeric	Telephone number of the representative named above. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). **Required if Injured Party has a representative.**
75	Representative Phone Extension	5	1176	1180	Alpha-numeric	Telephone extension number of representative named above. Fill with all spaces if unknown or not applicable.
76	Reserved for Future Use	60	1181	1240	Alpha-numeric	Fill with spaces.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
Settlement, Judgment, Award or Other Payment Information						
77	ORM Indicator	1	1241	1241	Alpha-numeric	Indication of whether there is on-going responsibility for medicals (ORM). Fill with Y if there is ongoing responsibility for medicals. Valid values: Y - Yes N – No **Required.**
78	ORM Termination Date	8	1242	1249	Numeric Date	Date on-going responsibility for medicals ended, where applicable. Only applies to claims submitted with ORM Indicator = Y. ORM Termination Date is not applicable if claimant retains the ability to submit/apply for payment for additional medicals related to the claim. Format: CCYYMMDD Fill with zeroes if not applicable.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
79	TPOC Start Date	8	1250	1257	Numeric Date	Initial date of Total Payment Obligation to the Claimant (TPOC) without regard to **ongoing** responsibility for medical services. Date payment obligation was established. This is the date the obligation is signed if there is a written agreement unless court approval is required. If court approval is required it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement it is the date the payment (or first payment if there will be multiple payments) is issued. Format: CCYYMMDD **Required.**
80	TPOC Amount	11	1258	1268	Numeric	Total Payment Obligation to the Claimant (TPOC) amount: Dollar amount of the total payment obligation to the claimant. If there is a structured settlement, the amount is the total payout amount. If a settlement provides for the purchase of an annuity, it is the total payout from the annuity. Specify dollars and cents with implied decimal. No formatting (no $, .) For example, an amount of $10,500.55 should be coded as 00001050055. **Required.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
81	Funding Delayed Beyond TPOC Start Date	8	1269	1276	Numeric Date	If funding for the Total Payment Obligation to Claimant is delayed, provide actual or estimated date of funding. Format: CCYYMMDD Fill with zeroes if not applicable.
82	Reserved for Future Use	10	1277	1286	Alpha-numeric	Fill with spaces
Claimant Information 1						
This section is only required if the Claimant is not the Injured Party/Medicare Beneficiary. The claimant may be the beneficiary's estate, or other claimant in the case of wrongful death or survivor action. Additional claimants must be listed on the Auxiliary Record. Fill the entire section (Fields 83-96) with spaces if not supplying Claimant 1 information. (This section is **not** used when the injured party/Medicare beneficiary is alive and an individual is pursuing a claim on behalf of the beneficiary. See the section for Injured Party's Attorney or Other Representative Information.)						
83	Claimant 1 Relationship	1	1287	1287	Alpha-numeric	Relationship of the claimant to the injured party/Medicare beneficiary. Valid values: E = Estate S = Spouse C = Child S = Sibling O = Other Space = Not applicable (rest of the section will be ignored) **Required if claimant is not the injured party.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
84	Claimant 1 TIN	9	1288	1296	Numeric	Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant 1. Must not match injured party named above or other claimant(s) listed on the Auxiliary Record. **Required if claimant is not the injured party.**
85	Claimant 1 Last Name	25	1297	1321	Alpha-betic	Surname of Claimant 1. **Required if claimant is not the injured party.**
86	Claimant 1 First Name	15	1322	1336	Alpha-betic	Given/First name of Claimant 1. **Required if claimant is not the injured party.**
87	Claimant 1 Middle Initial	1	1337	1337	Alpha-betic	First letter of Claimant 1's middle name.
88	Claimant 1 Mailing Address Line 1	40	1338	1377	Alpha-numeric	First line of the mailing address for the claimant named above. **Required if claimant is not the injured party.**
89	Claimant 1 Mailing Address Line 2	40	1378	1417	Alpha-numeric	Second line of the mailing address of the claimant named above.
90	Claimant City	30	1418	1447	Alpha-betic	Mailing address city for the claimant named above. **Required if claimant is not the injured party.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
91	Claimant 1 State	2	1448	1449	Alpha-betic	US Postal abbreviation state code for the claimant named above. **Required if claimant is not the injured party.**
92	Claimant 1 Zip	5	1450	1454	Numeric	5-digit Zip Code for the claimant named above. **Required if claimant is not the injured party.**
93	Claimant 1 Zip+4	4	1455	1458	Numeric	4-digit Zip+4 code for the claimant named above. If not applicable or unknown, fill with zeroes (0000).
94	Claimant 1 Phone	10	1459	1468	Numeric	Telephone number of the claimant named above. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). **Required if claimant is not the injured party.**
95	Claimant 1 Phone Extension	5	1469	1473	Alpha-numeric	Telephone extension number of the claimant named above. Fill with all spaces if unknown or not applicable.
96	Reserved for Future Use	60	1474	1533	Alpha-numeric	Fill with spaces.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
Claimant 1 Attorney/Other Representative Information						
This section is only required if Claimant 1 has a representative. Fill the entire section (Fields 97-110) with spaces if not supplying Claimant 1 representative information.						
97	Claimant 1 (C1) Representative Indicator	1	1534	1534	Alpha-numeric	Code indicating the type of Attorney/Other Representative information provided for Claimant 1. Valid values: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Space = Not applicable (rest of the section will be ignored) **Required if Claimant 1 has a representative.**
98	C1 Representative Last Name	25	1535	1559	Alpha-betic	Surname of C1 representative. **Required if Claimant 1 has a representative.**
99	C1 Representative First Name	15	1560	1574	Alpha-betic	Given/First name of C1 representative. **Required if Claimant 1 has a representative.**
100	C1 Representative Firm Name	40	1575	1614	Alpha-numeric	Representative's firm name. **Required if C1 is associated with a firm.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
101	C1 Representative TIN	9	1615	1623	Numeric	C1 Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN). **Required.**
102	C1 Representative Mail Address 1	40	1624	1663	Alpha-numeric	First line of the mailing address for the C1 representative named above. **Required if Claimant 1 has a representative.**
103	C1 Representative Mailing Address 2	40	1664	1703	Alpha-numeric	Second line of the mailing address of the C1 representative named above.
104	C1 Representative Mailing City	30	1704	1733	Alpha-betic	Mailing address city for the C1 representative named above. **Required if Claimant 1 has a representative.**
105	C1 Representative State	2	1734	1735	Alpha-betic	US Postal abbreviation state code for the C1 representative named above. **Required if Claimant 1 has a representative.**
106	C1 Representative Zip	5	1736	1740	Numeric	5-digit Zip Code for the C1 representative named above. **Required if Claimant 1 has a representative.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
107	C1 Representative Zip+4	4	1741	1744	Numeric	4-digit Zip+4 code for the C1 representative named above. If not applicable or unknown, fill with zeroes (0000).
108	C1 Representative Phone	10	1745	1754	Numeric	Telephone number of the C1 representative named above. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). **Required if Claimant 1 has a representative.**
109	C1 Representative Phone Extension	5	1755	1759	Alpha-numeric	Telephone extension number of the C1 representative named above. Fill with all spaces if unknown or not applicable.
110	Reserved for Future Use	41	1760	1800	Alpha-numeric	Fill with spaces.

MMSEA Section 111
Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Input Claim File Auxiliary Record – 1800 bytes

This record is only required if there are additional claimants to report for the associated Detail Claim Record. Do not include this record for the claim if there are no additional claimants to report. Claimant 1 on the Detail Claim Record must be completed in order for information concerning additional claimants to be accepted.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGCE'. **Required.**
2	DCN	10	5	14	Alpha-numeric	Document Control Number (DCN) assigned by the Section 111 RRE. Must match the DCN on the corresponding Detail Claim Record (Record Identifier NGCD). **Required.**
3	Injured Party HICN	12	15	26	Alpha-numeric	Must match the value in this field on the Detail Claim Record. **Required.**
4	Injured Party SSN	9	27	35	Numeric	Must match the value in this field on the Detail Claim Record. **Required.**
5	Injured Party Last Name	25	36	60	Alpha-betic	Must match the value in this field on the Detail Claim Record. **Required.**
6	Injured Party First Name	15	61	75	Alpha-betic	Must match the value in this field on the Detail Claim Record. **Required.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
Claimant 2 Information						
7	Claimant 2 Relationship	1	76	76	Alpha-numeric	Relationship of the claimant to the injured party/Medicare beneficiary. Valid values: E = Estate S = Spouse C = Child S = Sibling O = Other Space = Not applicable (rest of the section will be ignored) **Required.**
8	Claimant 2 TIN	9	77	85	Numeric	Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant 2. Must not match injured party named above or other claimant(s) listed on the Auxiliary Record. **Required.**
9	Claimant 2 Last Name	25	86	110	Alpha-betic	Surname of Claimant 2. **Required.**
10	Claimant 2 First Name	15	111	125	Alpha-betic	Given/First name of Claimant 2. **Required.**
11	Claimant 2 Middle Initial	1	126	126	Alpha-betic	First letter of Claimant 2's middle name.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
12	Claimant 2 Mailing Address Line 1	40	127	166	Alpha-numeric	First line of the mailing address for Claimant 2 named above. **Required.**
13	Claimant 2 Mailing Address Line 2	40	167	206	Alpha-betic	Second line of the mailing address for Claimant 2 named above.
14	Claimant 2 City	30	207	236	Alpha-betic	Mailing address city for Claimant 2 named above. **Required.**
15	Claimant 2 State	2	237	238	Alpha-betic	US Postal abbreviation state code for Claimant 2 named above. **Required.**
16	Claimant 2 Zip	5	239	243	Numeric	5-digit Zip Code for Claimant 2 named above. **Required.**
17	Claimant 2 Zip+4	4	244	247	Numeric	4-digit Zip+4 code for Claimant 2 named above. If not applicable or unknown, fill with zeroes (0000).
18	Claimant 2 Phone	10	248	257	Numeric	Telephone number of Claimant 2 named above. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). **Required.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
19	Claimant 2 Phone Extension	5	258	262	Alpha-numeric	Telephone extension number of Claimant 2 named above. Fill with all spaces if unknown or not applicable.
20	Filler	60	263	322	Alpha-numeric	Fill with spaces.
Claimant 2 Attorney/Other Representative Information						
This section is only required if Claimant 2 has a representative. Fill the entire section (Field 21-34) with spaces if not supplying Claimant 2 representative information.						
21	Claimant 2 (C2) Representative Indicator	1	323	323	Alpha-numeric	Code indicating the type of Attorney/Other Representative information provided for Claimant 2 (C2). Valid values: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Space = Not applicable (rest of the section will be ignored) **Required if Claimant 2 has a representative.**
22	C2 Representative Last Name	25	324	348	Alpha-betic	Surname of C2 attorney or representative. **Required if Claimant 2 has a representative.**
23	C2 Representative First Name	15	349	363	Alpha-betic	Given/First name of C2 attorney or representative. **Required if Claimant 2 has a representative.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
24	C2 Representative Firm Name	40	364	403	Alpha-numeric	Representative's firm name. **Required if C2 Representative is associated with a firm.**
25	C2 Representative TIN	9	404	412	Numeric	C2 Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN). **Required.**
26	C2 Representative Mailing Address Line 1	40	413	452	Alpha-numeric	First line of the mailing address for the C2 representative named above. **Required if Claimant 2 has a representative.**
27	C2 Representative Mailing Address Line 2	40	453	492	Alpha-numeric	Second line of the mailing address of the C2 representative named above.
28	C2 Representative City	30	493	522	Alpha-betic	Mailing address city for the C2 representative named above. **Required if Claimant 2 has a representative.**
29	C2 Representative State	2	523	524	Alpha-betic	US Postal abbreviation state code for the C2 representative named above. **Required if Claimant 2 has a representative.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
30	C2 Representative Zip	5	525	529	Numeric	5-digit Zip Code for the C2 representative named above. **Required if Claimant 2 has a representative.**
31	C2 Representative Zip+4	4	530	533	Numeric	4-digit Zip+4 code for the C2 representative named above. If not applicable or unknown, fill with zeroes (0000).
32	C2 Representative Phone	10	534	543	Numeric	Telephone number of the C2 representative named above. Format with 3-digit area code followed by 7-digit phone number with no dashes or other punctuation (e.g. 1112223333). **Required if Claimant 2 has a representative.**
33	C2 Representative Phone Extension	5	544	548	Alpha-numeric	Telephone extension number of the C2 representative named above. Fill with all spaces if unknown or not applicable.
34	Filler	60	549	608	Alpha-numeric	Fill with spaces.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
Claimant 3 Information						
Fill entire section with spaces if not applicable. ***See Claimant 2 Information section above for individual field specifications***.						
35	Claimant 3 Relationship	1	609	609	Alpha-numeric	Relationship of the claimant to the injured party/Medicare beneficiary. Valid values: E = Estate S = Spouse C = Child S = Sibling O = Other Space = Not applicable (rest of the section will be ignored)
36	Claimant 3 TIN	9	610	618	Numeric	
37	Claimant 3 Last Name	25	619	643	Alpha-betic	
38	Claimant 3 First Name	15	644	658	Alpha-betic	
39	Claimant 3 Middle Initial	1	659	659	Alpha-betic	
40	Claimant 3 Mailing Address Line 1	40	660	699	Alpha-numeric	
41	Claimant 3 Mailing Address Line 2	40	700	739	Alpha-numeric	
42	Claimant 3 City	30	740	769	Alpha-betic	
43	Claimant 3 State	2	770	771	Alpha-betic	
44	Claimant 3 Zip	5	772	776	Numeric	
45	Claimant 3 Zip+4	4	777	780	Numeric	

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
46	Claimant 3 Phone	10	781	790	Numeric	
47	Claimant 3 Phone Extension	5	791	795	Alpha-numeric	
48	Filler	60	796	855	Alpha-numeric	Fill with spaces.
Claimant 3 Attorney/Representative Information						
This section is only required if Claimant 3 has a representative. Fill the entire section (Field 49-62) with spaces if not supplying Claimant 3 representative information. ***See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.***						
49	Claimant 3 (C3) Representative Indicator	1	856	856	Alpha-numeric	
50	C3 Representative Last Name	25	857	881	Alpha-betic	
51	C3 Representative First Name	15	882	896	Alpha-betic	
52	C3 Representative Firm Name	40	897	936	Alpha-numeric	
53	C3 Representative TIN	9	937	945	Numeric	
54	C3 Representative Mailing Address Line 1	40	946	985	Alpha-numeric	
55	C3 Representative Mailing Address Line 2	40	986	1025	Alpha-numeric	
56	C3 Representative City	30	1026	1055	Alpha-betic	

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
57	C3 Representative State	2	1056	1057	Alpha-betic	
58	C3 Representative Zip	5	1058	1062	Numeric	
59	C3 Representative Zip+4	4	1063	1066	Numeric	
60	C3 Representative Phone	10	1067	1076	Numeric	
61	C3 Representative Phone Extension	5	1077	1081	Alpha-numeric	
62	Filler	60	1082	1141	Alpha-numeric	Fill with spaces.
Claimant 4 Information						
Fill entire section with spaces if not applicable. ***See Claimant 2 Information section above for individual field specifications***.						
63	Claimant 4 Relationship	1	1142	1142	Alpha-numeric	
64	Claimant 4 TIN	9	1143	1151	Numeric	
65	Claimant 4 Last Name	25	1152	1176	Alpha-betic	
66	Claimant 4 First Name	15	1177	1191	Alpha-betic	
67	Claimant 4 Middle Initial	1	1192	1192	Alpha-betic	
68	Claimant 4 Mailing Address Line 1	40	1193	1232	Alpha-numeric	
69	Claimant 4 Mailing Address Line 2	40	1233	1272	Alpha-numeric	
70	Claimant 4 City	30	1273	1302	Alpha-betic	

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
71	Claimant 4 State	2	1303	1304	Alpha-betic	
72	Claimant 4 Zip	5	1305	1309	Numeric	
73	Claimant 4 Zip+4	4	1310	1313	Numeric	
74	Claimant 4 Phone	10	1314	1323	Numeric	
75	Claimant 4 Phone Extension	5	1324	1328	Alpha-numeric	
76	Filler	60	1329	1388	Alpha-numeric	Fill with spaces.
Claimant 4 Attorney/Representative Information						
This section is only required if Claimant 4 has a representative. Fill the entire section (Field 77-90) with spaces if not supplying Claimant 4 representative information. ***See corresponding Claimant 2 Attorney/Representative Information section for individual field specifications.***						
77	Claimant 4 (C4) Representative Indicator	1	1389	1389	Alpha-betic	
78	C4 Representative Last Name	25	1390	1414	Alpha-betic	
79	C4 Representative First Name	15	1415	1429	Alpha-betic	
80	C4 Representative Firm Name	40	1430	1469	Alpha-numeric	
81	C4 Representative TIN	9	1470	1478	Numeric	
82	C4 Representative Mailing Address Line 1	40	1479	1518	Alpha-numeric	
83	C4 Representative Mailing Address Line 2	40	1519	1558	Alpha-numeric	
84	C4 Representative City	30	1559	1588	Alpha-betic	
85	C4 Representative State	2	1589	1590	Alpha-betic	

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
86	C4 Representative Zip	5	1591	1595	Numeric	
87	C4 Representative Zip+4	4	1596	1599	Numeric	
88	C4 Representative Phone	10	1600	1609	Numeric	
89	C4 Representative Phone Extension	5	1610	1614	Alpha-numeric	
90	Filler	60	1615	1674	Alpha-numeric	
91	Reserved for Future Use	126	1675	1800	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Input Claim File Trailer Record – 1800 bytes						
Field No.	**Name**	**Len**	**Start Pos.**	**End Pos.**	**Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGCT' **Required.**
2	Section 111 Reporter ID	9	5	13	Numeric	COBC assigned Section 111Reporter ID #. **Required.**
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Must be 'NGHPCLM' **Required.**
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the COBC. Format: CCYYMMDD **Required.**
5	File Record Count	7	29	35	Numeric	Number of records contained within file (do not include header or trailer records in the count) **Required.**
6	Filler	1765	36	1800	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Mandatory Reporting - Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation

TIN Reference File Layout – to be submitted with the Input Claim File

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference File Header Record – 1800 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGTH' **Required.**
2	Section 111 Reporter ID	9	5	13	Alpha-numeric	COBC assigned Section 111Reporter ID #. **Required.**
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Must be 'NGHPTIN' **Required.**
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the COBC. Format: CCYYMMDD **Required.**
5	Filler	1772	29	1800	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation TIN Reference File Detail TIN/Site ID Record – 1800 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGTD' **Required.**
2	Section 111 Reporter ID	9	5	13	Numeric	COBC assigned Section 111Reporter ID #. **Required.**
3	TIN	9	14	22	Numeric	Federal Tax Identification Number of the insurer, applicable plan (s), workers' compensation law/plan (s), or self-insured entities reported in Field 47 of each Detail Claim Record. Used in conjunction with the Site ID reported in Field 48 of the Detail Claim Record. Also know as the Employer Identification Number (EIN). Each TIN/Site ID combination reported in Fields 47 and 48 of the Detail Claim Records must have a corresponding record reported on the TIN Reference File. A record must be submitted on the TIN Reference File for each unique TIN/Site ID combination. **Required.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
4	TIN Site ID	3	23	25	Numeric	3 digit identifier to uniquely identify variations in insurer addresses/claim offices/Plan Contact Address as reported in Field 48 of each Detail claim Record. Used in conjunction with the TIN reported in Field 47 of the Detail Claim record to uniquely specify different addresses associated with one TIN. If only one address will be used per reported TIN, fill with zeroes. Each TIN/Site ID combination reported in Fields 47 and 48 of the Detail Claim Records must have a corresponding record reported on the TIN Reference File. A record must be submitted on the TIN Reference File for each unique TIN/Site ID combination. ***Required.***
5	TIN/Site ID Mailing Name	32	26	57	Alpha-numeric	Name associated with the RRE reflected by the unique TIN/Site ID combination. **Required.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
6	TIN/Site ID Mailing Address Line 1	32	58	89	Alpha-numeric	First line of the address associated with the unique TIN/Site ID combination reflected on this record. This mailing address should reflect where the RRE wishes to have the recoveries and other associated correspondence directed for the TIN/Site ID combination. **Required.**
7	TIN/Site ID Mailing Address Line 2	32	90	121	Alpha-numeric	Second line of the address associated with the unique TIN/Site ID combination reflected on this record. This mailing address should reflect where the RRE wishes to have the recoveries and other associated correspondence directed for the TIN/Site ID combination. **Required.**
8	TIN/Site/ID City	32	122	153	Alpha-numeric	City of the address associated with the unique TIN/Site ID combination reflected on this record. This mailing address should reflect where the RRE wishes to have the recoveries and other associated correspondence directed for the TIN/Site ID combination. **Required.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
9	TIN/Site ID State	2	154	155	Alpha-numeric	US Postal state abbreviation of the address associated with the unique TIN/Site ID combination reflected on this record. This mailing address should reflect where the RRE wishes to have the recoveries and other associated correspondence directed for the TIN/Site ID combination. **Required.**
10	TIN/Site ID Zip	5	156	160	Numeric	5-digit Zip Code of the address associated with the unique TIN/Site ID combination reflected on this record. **Required.**
11	TIN/Site ID Zip+4	4	161	164	Numeric	4-digit Zip+4 code of the address associated with the unique TIN/Site ID combination reflected on this record. If not applicable fill with zeroes (0000).
12	Filler	1636	165	1800	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation TIN Reference File Trailer Record – 1800 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Date Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Must be 'NGTT' **Required.**
2	Section 111 Reporter ID	9	5	13	Numeric	COBC assigned Section 111Reporter ID #. **Required.**
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Must be 'NGHPTIN' **Required.**
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the COBC. Format: CCYYMMDD **Required.**
5	File Record Count	7	29	35	Numeric	Number of records contained within this TIN Reference File (do not include header or trailer records in count) **Required.**
6	Filler	1765	36	1800	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Mandatory Reporting - Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation

Claim Response File Layout

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Header Record – 350 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Contains value of 'NGRH' COBC supplied.
2	Section 111 Reporter ID	9	5	13	Numeric	COBC assigned Section 111Reporter ID #. As supplied by RRE input record.
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Contains value of 'NGHPRSP' COBC supplied.
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the RRE. Format: CCYYMMDD COBC supplied.
5	Reserved	322	29	350	Alpha-numeric	Contains all spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 350 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Contains value of 'NGRD' COBC supplied.
2	Submitted DCN	10	5	14	Alpha-numeric	Document Control Number (DCN) submitted by RRE on input record. Used for matching input records with response records. As supplied by RRE on input record.
3	Submitted Action Type	1	15	15	Numeric	Action to be performed. As supplied by RRE on input record.
4	Injured Party HICN	12	16	27	Alpha-numeric	Health Insurance Claim Number (HICN) of Injured Party. As supplied by RRE on input record.
5	Submitted Injured Party SSN	9	28	36	Numeric	Social Security Number of Injured Party. As supplied by RRE on input record.
6	Submitted Injured Party Last Name	25	37	61	Alpha-betic	As supplied by RRE on input record.
7	Submitted Injured Party First Name	15	62	76	Alpha-betic	As supplied by RRE on input record.
8	Submitted Injured Party Middle Init	1	77	77	Alpha-betic	As supplied by RRE on input record.
9	Submitted Injured Party Gender	1	78	78	Numeric	As supplied by RRE on input record.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
10	Submitted Injured Party DOB	8	79	86	Numeric Date	As supplied by RRE on input record.
11	Submitted Plan TIN	9	87	95	Numeric	As supplied by RRE on input record.
12	Submitted Plan Site ID	3	96	98	Numeric	As supplied by RRE on input record.
13	Filler	20	99	118	Alpha-numeric	Filled with spaces.
14	Applied Injured Party HICN	12	119	130	Alpha-numeric	Current Medicare Health Insurance Claim Number (HICN) of Injured Party if confirmed to be a Medicare beneficiary. COBC supplied.
15	Applied Injured Party SSN	9	131	139	Numeric	Social Security Number (SSN) of Injured Party if confirmed to be a Medicare beneficiary. COBC supplied.
16	Applied Injured Party Last Name	25	140	164	Alpha-betic	Injured Party Last Name if confirmed to be a Medicare beneficiary. COBC supplied.
17	Applied Injured Party First Name	15	165	179	Alpha-betic	Injured Party First Name if confirmed to be a Medicare beneficiary. COBC supplied.
18	Applied Injured Party Middle Initial	1	180	180	Alpha-betic	Injured Party Middle Initial if confirmed to be a Medicare beneficiary. COBC supplied.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
19	Applied Injured Party Gender	1	181	181	Numeric	Sex of Injured Party if confirmed to be a Medicare beneficiary. COBC supplied. 1 - Male 2 - Female
20	Applied Injured Party DOB	8	182	189	Numeric Date	Date of birth (DOB) of Injured Party if confirmed to be a Medicare beneficiary. Format: CCYYMMDD COBC supplied.
21	Applied MSP Effective Date	8	190	197	Numeric Date	Applied Medicare Secondary Payer (MSP) effective date. If injured party is found to be a Medicare beneficiary, the start date of Medicare's secondary payment status for the incident, illness or injury. Will be the later of the beneficiary's Medicare entitlement/eligibility start date or the date of the initial incident, illness or injury. This is the effective date of the MSP occurrence posted to the Medicare Common Working File (CWF) which is used in Medicare claim payment determinations. Format: CCYYMMDD COBC supplied.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
22	Applied MSP Termination Date	8	198	205	Numeric Date	Applied Medicare Secondary Payment (MSP) Termination Date. If injured party is found to be a Medicare beneficiary, the end date of Medicare's secondary payment status for the incident, illness or injury. This is the end date of the MSP occurrence posted to the Medicare Common Working File (CWF) which is used in Medicare claim payment determinations. Format: CCYYMMDD Will contain all zeroes if open-ended. COBC supplied.
23	Applied MSP Type Indicator	1	206	206	Alpha-numeric	Applied Medicare Secondary Payer (MSP) Type. D = No-Fault E = Workers' Compensation L = Liability COBC supplied.
24	Filler	20	207	226	Alpha-numeric	Reserved for future use. Filled with spaces.
25	Applied Disposition Code	2	227	228	Alpha-numeric	2-digit code indicating how the record was processed. Will indicate whether the submitted record was in error or whether Medicare is the secondary payer. See Disposition Code Table for values. COBC supplied.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
26	Applied Error Code 1	5	229	233	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error. See Error Code Table for values. COBC supplied.
27	Applied Error Code 2	5	234	238	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 2 errors were found. See Error Code Table for values. COBC supplied.
28	Applied Error Code 3	5	239	243	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 3 errors were found. See Error Code Table for values. COBC supplied.
29	Applied Error Code 4	5	244	248	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 4 errors were found. See Error Code Table for values. COBC supplied.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
30	Applied Error Code 5	5	249	253	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 5 errors were found. See Error Code Table for values. COBC supplied.
31	Applied Error Code 6	5	254	258	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 6 errors were found. See Error Code Table for values. COBC supplied.
32	Applied Error Code 7	5	259	263	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 7 errors were found. See Error Code Table for values. COBC supplied.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
33	Applied Error Code 8	5	264	268	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 8 errors were found. See Error Code Table for values. COBC supplied.
34	Applied Error Code 9	5	269	273	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 9 errors were found. See Error Code Table for values. COBC supplied.
35	Applied Error Code 10	5	274	278	Alpha-numeric	Code associated with an error found by the COBC in the submitted record. Provided only if disposition code denotes error and at least 10 errors were found. See Error Code Table for values. COBC supplied.
36	Filler	72	279	350	Alpha-numeric	Reserved for future use. Filled with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Trailer Record – 350 bytes						
Field No.	**Name**	**Size**	**Start Pos.**	**End Pos.**	**Data Type**	**Description**
1	Record Identifier	4	1	4	Alpha-numeric	Contains value of 'NGRT' COBC supplied.
2	Section 111 Reporter ID	9	5	13	Numeric	COBC assigned Section 111Reporter ID #. As supplied by RRE input record.
3	Section 111 Reporting File Type	7	14	20	Alpha-numeric	Contains value of 'NGHPRSP' COBC supplied.
4	File Submission Date	8	21	28	Numeric Date	Date file was transmitted to the RRE. Format: CCYYMMDD COBC supplied.
4	File Record Count	7	29	35	Numeric	Number of detail response records contained within file (does not include header or trailer records). COBC supplied.
5	Filler	315	36	350	Alpha-numeric	Reserved for future use. Filled with spaces.