COL	FIELD	LENGTH	NOTES
1	NEAR-LINE RECORD IDENTIFICATION CODE (3) **(ric_cd)**	1	Claim Near-Line Record Identification Code O - Part B (CWFB) Physician/Supplier Claim Record V - Part A Institutional claim record (Inpatient (IP), Skilled Nursing Facility (SNF), Christian Science (CS), Home Health Agency (HHA) or Hospice) W - Part B Institutional claim record (Outpatient (OP), HHA) M - Part B (CWFB) DMEPOS claim record (Effective 10/93) U - Both Part A and B institutional HHA claim records – due to HHPPS and HHA A/B split. (eff. 10/00)
2	NEAR-LINE RECORD VERSION (2) **(rec_lvl)**	1	Record version of Near-Line file storing Institutional or CWFB claims data. Record format as of: A - January 1991 B - April 1991 C - May 1991 D - January 1992 E - March 1992 F - May 1992 G - October 1993 H - September 1998 I - July 2000
3	ID **(regcase)**	11	Use first 10 characters only for SEER Cases
	SEER Cases		
3	REGISTRY	2	02 - Connecticut 20 - Detroit 21 - Hawaii 22 - Iowa 23 - New Mexico 25 - Seattle 26 - Utah 27 - Atlanta 33 - Arizona Indians 37 - Rural Georgia 42 - Kentucky 43 - Louisiana 44 - New Jersey

Note: The number in parenthesis corresponds to the number of the variable on the HCFA version I file documentation.

COL	FIELD	LENGTH	NOTES
3	Registry (cont.)		88 - California
5	CASE NUMBER	8	Encrypted SEER case #
13	FILLER	1	
	Non-cancer Patients		
3	HIC **(hicbic)**	11	
14	BENEFICIARY IDENTIFICATION CODE (BIC) (8) **(bic)**	2	Relationship between an individual and a primary Beneficiary. (Refer to Appendix table BIC)
16	SSA STANDARD STATE CODE (10) **(state_cd)**	2	State of Beneficiary's residence, SSA Standard Code. (Refer to Appendix table STATE_CD)
18	SSA STANDARD COUNTY CODE (30) **(cnty_cd)**	3	County of Beneficiary's residence, SSA Standard Code.
21	MAILING CONTACT ZIP CODE (37) **(bene_zip)**	9	Beneficiary's mailing address zip code. *** Special Permission Required**.
30	SEX (38) **(sex)**	1	Sex of a Beneficiary. 1 - Male 2 - Female 0 - Unknown
31	RACE (39) **(race)**	1	Race of a Beneficiary. 1 - White 2 - Black 3 - Other 4 - Asian 5 - Hispanic 6 - North American Native 0 - Unknown
40	CWF BENEFICIARY MEDICARE STATUS (41) **(ms_cd)**	2	Medicare entitlement reason. 10 - Aged without ESRD 11 - Aged with ESRD 20 - Disabled without ESRD 21 - Disabled with ESRD 31 - ESRD only

Note: The number in parenthesis corresponds to the number of the variable on the HCFA version I file documentation.

COL	FIELD	LENGTH	NOTES
50	CLAIM FROM DATE (11) **(from_dtm, from_dtd, from_dty)**	8	For Institutional or CWFB Claim, firstday of Provider's or Physician/Supplier's billing statement. MMDDYYYY
58	CLAIM THROUGH DATE (12) **(thru_dtm,thru_dtd, thru_dty)**	8	Last day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
66	CLAIM DISPOSITION CODE (27) **(disp_cd)**	2	Outcome of Institutional processing. 01- Debit Accepted 02- Debit Accepted (Automatic Adjustment) 03- Void (Cancel) Accepted 61- *Conversion code: debit accepted 62- *Conversion code: debit accepted(automatic adjustment) 63- *Conversion code: cancel accepted. *used only during conversion period: 1/1/91 - 2/21/91
68	CARRIER NUMBER (34) **(fi_num)**	5	Fiscal Intermediary/Carrier Identification Number. Assigned by HCFA to an Intermediary authorized to process claims from Providers or to a Carrier authorized to process claims from Physician/Suppliers. (Refer to Appendix Table FI_NUM for NCH)
73	CARRIER CLAIM PAYMENT DENIAL CODE (48) **(pmtdnlcd)**	1	Indicates to whom payment was made, or if a claim was denied. (Refer to Appendix table PMTDNLCD)
88	CARRIER CLAIM PROVIDER ASSIGNMENT INDICATOR SWITCH(55) **(asgmntcd)**	1	Whether the provider accepts assignment for the INDICATOR SWITCH claim. A - Assigned claim N - Non-assigned claim

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COL	FIELD	LENGTH	NOTES
89	CARRIER CLAIM REFERRING UPIN NUMBER (53) **(rfr_upin)**	6	Unique Physician Identification Number (UPIN) UPIN NUMBER of physician who referred beneficiary to physician that performed the Part B services. **Encrypted data. * Special Permission required for unencrypted data.**
95	CARRIER CLAIM DIAGNOSIS CODE COUNT (76) **(cdgncnt)**	1	The count of the number of diagnosis codes reported on the carrier claim.
96	CARRIER CLAIM BENEFICIARY PAID AMOUNT (58) **(benepaid)**	15.2	The amount paid by the beneficiary for the non-institutional Part B services.
111	CARRIER CLAIM CASH DEDUCTIBLE APPLIED AMOUNT (61) **(dedapply)**	15.2	The amount of the cash deductible as submitted on the claim.
126	CARRIER CLAIM HCPCS YEAR CODE (62) **(hcpcs_yr)**	1	The terminal digit of HCPCS version used to code the claim.
127	CARRIER CLAIM LINE COUNT (77) **(clinecnt)**	2	The count of the number of line items reported on the carrier claim.
129	CARRIER CLAIM PRIMARY PAYER PAID AMOUNT (51) **(prpayamt)**	15.2	The Amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.
144	CLAIM BLOOD DEDUCTIBLE PINTS QUANTITY (70) **(bld_ded)**	4	The quantity of blood pints applied (blood deductible) as reported on the carrier claim (non-DMERC).
148	CLAIM BLOOD PINTS FURNISHED QUANTITY (69) **(bldfrnsh)**	4	Number of whole pints of blood furnished to the beneficiary, as reported on the carrier claim (non-DMERC).

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COL	FIELD	LENGTH	NOTES
152	CLAIM PAYMENT AMOUNT (50) **(pmt_amt)**	15.2	Amount of payment made from the Medicare trust fund for the services covered by the claim record.
167	Principle Diagnosis **(pdgns_cd)**	5	Beneficiaries principle diagnosis code.
172	NCH CARRIER CLAIM ALLOWED CHARGE AMOUNT (60) **(alowchrg)**	15.2	The total allowed charges on the claim (the sum of line item allowed charges).
187	NCH CARRIER CLAIM SUBMITTED CHARGE AMOUNT (59) **(sbmtchrg)**	15.2	The total submitted charges on the claim (the sum of line item submitted charges).
202	NCH CLAIM BENEFICIARY PAYMENT AMOUNT (57) **(bene_pmt)**	15.2	The total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary).
217	NCH CLAIM PROVIDER PAYMENT AMOUNT (56) **(prov_pmt)**	15.2	The total payments made to the provider for this claim (sum of line item provider payment amounts).
232	LINK NUMBER **(link_num)**	10	A system generated number used to identify claims.
261	CARRIER LINE PERFORMING UPIN NUMBER(101) **(perupin)**	6	Unique identifier of physician performing the UPIN NUMBER procedure specified by the HCPCS code. **Encrypted data. * Special Permission required for unencrypted data.**
267	CARRIER LINE PROVIDER TYPE CODE (104) **(prv_type)**	1	Code identifying the type of provider furnishing the service for this line item on the Part B claim. (Refer to Appendix table PRV_TYPE)
268	LINE NCH PROVIDER STATE CODE (106) **(prvstate)**	2	SSA State code where provider facility is located.

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COL	FIELD	LENGTH	NOTES
270	CARRIER LINE PERFORMING PROVIDER ZIP CODE (107) **(prozip)**	9	Zip code of the physician/supplier who performed the Part B service for this line item. *** Special Permission Required.**
279	LINE HCFA PROVIDER SPEC CODE (108) **(hcfaspec)**	2	HCFA Specialty code used for pricing the service for this line item on the CWFB claim. (Refer to Appendix table HCFASPEC)
281	CARRIER LINE PROVIDER SPEC CODE (109) **(carrspec)**	2	Carrier's specialty code for the provider(usually different from HCFA's) used for pricing the service for this line item on the CWFB claim. (Carrier Information File)
283	LINE PROVIDER PART. INDICATOR CODE (110) **(prtcptg)**	1	Code indicating whether or not a provider is participating or accepting assignment for this line item on the Part B claim. 1 - Participating 2 - All or some covered and allowed expenses applied to deductible participating 3 - Assignment accepted/non participating 4 - Assignment not accepted/ non-participating 5 - Assignment accepted but all or some covered and allowed expenses applied to deductible non-participation 6 - Assignment not accepted and all covered and allowed expenses applied to deductible non-participating 7 - Participating provider not accepting assignment
284	CARRIER LINE REDUCED PAYMENT PHYSICIAN ASSISTANT CODE (111) **(astnt_cd)**	1	Code that identifies claims that have been paid a reduced fee schedule amount (65%, 75%, or 85%) because a phys assist. performed the services Blank - Adjustment situation 0 - N/A

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COL	FIELD	LENGTH	NOTES
			1 - 65% A) Physician assistants assisting in surgery B) Nurse midwives 2 - 75% A) Physician assistants performing services in a hospital (other than assisting surgery) B) Nurse practitioners and clinical nurse specialists performing services in rural areas C) Clinical social worker services 3 - 85% A) Physician assistant services for other than assisting surgery B) Nurse practitioners services
285	LINE SERVICE COUNT (112) **(srvc_cnt)**	4	Count of the total number of services processed.
289	LINE HCFA TYPE SERVICE CODE (113) **(hcfatype)**	1	Code indicating the type of service, as defined in the HCFA Medicare Carrier Manual, for this line item on the CWFB claim. (Refer to Appendix table HCFATYPE)
290	CARRIER LINE TYPE OF SERVICE (114) **(carrtype)**	2	Carrier's type of service code (usually different from HCFA's) used for pricing this service.
292	LINE PLACE OF SERVICE CODE (115) **(plcsrvc)**	2	Place of service for this procedure code. (Refer to Appendix table PLCSRVC)
294	LINE FIRST EXPENSE DATE (117) **(frexpenm, frexpend, frexpeny)**	8	Beginning date for this service. MMDDYYYY
302	LINE LAST EXPENSE DATE (118) **(lsexpenm, lsexpend lsexpeny)**	8	Ending date for this service. MMDDYYYY

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COL	FIELD	LENGTH	NOTES
310	LINE HCPCS CODE (119) **(hcpcs)**	5	Health Care Financing Administration Common Procedure Coding System (HCPCS) code. Procedures, supplies, products or services provided to Medicare Beneficiaries. (Refer to Appendix table HCPCS)
315	LINE HCPCS INITIAL MODIFIER CODE (120) **(mfrcd1)**	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information file)
317	LINE HCPCS SECOND MODIFIER CODE (121) **(mfrcd2)**	2	Second modifier to enable a more specific procedure ID. (Carrier Information file)
319	BETOS CODE (122) **(betos)**	3	Berenson-Eggers type of service (Betos) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. (Refer to Appendix table BETOS)
322	LINE PAYMENT AMOUNT (125) **(linepmt)**	15.2	Amount of payment made to provider and/or beneficiary for the services covered
337	LINE BENEFICIARY PAYMENT AMOUNT (126) **(lbenpmt)**	15.2	The payment (reimbursement) made to the beneficiary related to the line item service on the non-institutional claim.
352	LINE PROVIDER PAYMENT AMOUNT (127) **(lprvpmt)**	15.2	The payment made to the provider for the line item service on the non-institutional claim.
367	LINE BENEFICIARY PART B DEDUCTIBLE AMOUNT (128) **(ldedamt)**	15.2	The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B deductible on the CWFB claim.
382	LINE BENEFICIARY PRIMARY PAYER CODE (129) **(lprpaycd)**	1	Specifies a federal non-medicare program or other source that has primary responsibility for the payment of the medicare bene's medical bills.(Refer to Appendix table PRPAY_CD)

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COL	FIELD	LENGTH	NOTES
383	LINE BENEFICIARY PRIMARY PAYER PAID AMOUNT (130) **(lprpayat)**	15.2	Amount of a payment made on behalf of a medicare bene by a primary payer other than medicare, that the provider is applying to covered medicare charges on an CWFB claim.
398	LINE COINSURANCE AMOUNT (131) **(coinamt)**	15.2	The beneficiary coinsurance liability amount for this line item service on the non-institutional claim.
413	CARRIER LINE PSYCHIATRIC, OCCUPATIONAL THERAPY, PHYSICAL THERAPY LIMIT AMOUNT (132) **(llmtamt)**	15.2	For type of service psychiatric, occupational therapy or physical therapy, the amount of allowed charges applied toward the limit cap for this line item.
428	LINE PRIMARY PAYER ALLOWED CHARGE AMOUNT (134) **(prpyalow)**	15.2	The primary payer allowed charge amount for the line item service on the non-institutional claim.
443	CARRIER LINE BLOOD DEDUCTIBLE PINTS QUANTITY (136) **(blood)**	4	The blood pints quantity (deductible) for the line item.
447	LINE SUBMITTED CHARGE AMOUNT (137) **(submamt)**	15.2	The amount of submitted charges reported on the line item on the CWFB claim.
462	LINE ALLOWED CHARGE AMOUNT (138) **(alowamt)**	15.2	The amount of allowed charges reported on the line item on the CWFB claim.
477	CARRIER LINE CLINICAL LAB NUMBER (139) **(lab_num)**	10	The id number assigned to the clinical lab providing services.
487	CARRIER LINE CLINICAL LAB CHARGE AMOUNT (140) **(lab_amt)**	15.2	Fee schedule charge amount applied for clinical lab services.
502	LINE PROCESSING INDICATOR CODE (141) **(proindcd)**	1	The code indicating the reason a line item on the CWFB claim was allowed or denied. A - Allowed B - Benefits exhausted C - Non-covered care

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COL	FIELD	LENGTH	NOTES
			D - Denied (existed prior to 91 from BMAD) I - Invalid data L - CLIA (eff 9/92) M - Multiple submittal - duplicate line item N - Medically unnecessary O - Other P - Physician ownership denial (eff 3/92) Q - MSP cost avoided (contractor #88888) - voluntary agreement (eff 1/98) R - Reprocessed--adjustments based on subsequent reprocessing of claim S - Secondary payer T - MSP cost avoided - IEQ contractor U - MSP cost avoided - HMO rate cell adjustment (eff 7/96) V - MSP cost avoided - litigation settlement (eff 7/96) X - MSP cost avoided - generic Y - MSP cost avoided - IRS/SSA data match project Z - Zero payment; allowed tests (eff 1/1/98)
503	LINE PAYMENT 80/100% CODE (142) **(pay80cd)**	1	The code indicating that the amount shown in the payment field on the CWFB claim represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only. 0 - 80% 1 - 100% 3 - 100% limitation of liability only
504	LINE SERVICE DEDUCTIBLE INDICATOR SWITCH (143) **(dedind)**	1	Switch indicating whether or not the service reflected on the line item on the CWFB claim is subject to deductible. 0 - Service subject to deductible 1 - Service not subject to deductible

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COL	FIELD	LENGTH	NOTES
505	LINE PAYMENT INDICATOR CODE(144) **(payindcd)**	1	Code that indicates the payment screen used to determine the allowed charge for the line item on the CWFB claim. 1 - Actual charge 2 - Customary charge 3 - Prevailing charge 4 - Other 5 - Lab fee schedule 6 - Physician fee schedule (full fee schedule amt) 7 - Physician fee schedule (transition) 8 - Clinical psychologist fee schedule 9 - DME and prosthetics/ orthotics fee schedule (eff 4/97)
506	CARRIER MILES/TIME/UNITS/ SERVICES COUNT (145) **(mtuscnt)**	4	The count of the total units associated with services needing unit reporting such as transportation, miles, anesthesia time units, number of services, volume of oxygen or blood units. This is a line item on the CWFB claim and is used for both allowed and denied services.
510	CARRIER MILES/TIME/UNITS/SERVICES INDICATOR CODE (146) **(mtusind)**	1	Code indicating the units associated with services needing unit reporting on the line item for the CWFB claim. 0 - Values reported as zero (no allowed activities) 1 - Transportation(ambulance) miles 2 - Anesthesia time units 3 - Services 4 - Oxygen units 5 - Units of blood 6 - Anesthesia base and time units (prior to 91; from BMAD)
511	LINE DIAGNOSIS CODE (147) **(linediag)**	5	ICD-9-CM code indicating diagnosis supporting this procedure/service.

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COL	FIELD	LENGTH	NOTES
516	CLAIM DIAGNOSIS CODES (97) (**dgn_cd1-dgn_cd4**)	5*4	Up to four 5 digit ICD-9 diagnosis codes. For persons with less than four codes the columns are blank filled.
536	YEAR OF FILE **(year)**	4	Year of the File.
540	Record Count **(rec_count)**	3	Record count for each claim.
543	Filler	1	

Note: The number in parenthesis corresponds to the number of the variable on the HCFA version I file documentation.