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 79). 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 49 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 Office Code/Site ID submitted in Fields 49 and 50 of the Claim File detail records must have a corresponding TIN/Site ID combination on the TIN Reference File. For example, an RRE may use only one TIN (123456789) but have two office codes or site IDs; 01 for Workers' Compensation claims and 02 for Commercial Liability Claims. Two records will be reported on the TIN Reference File. One record with TIN of 123456789 and

Office Code/Site ID of 01 and a second record with the same TIN of 123456789 but Office Code/Site ID of 02. Different mailing addresses may be submitted on the TIN Reference File for each of these entries. In this example, the RRE would submit 123456789 in Field 49 of each claim detail record, 01 in Field 50 of each Workers' Compensation claim detail record, and 02 in Field 50 of each Commercial Liability claim detail record.

- Subsequent Claim Files do not need to be accompanied by a TIN Reference File unless changes to previously submitted TIN/Site ID information must be submitted or new 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

<table>
<tr>
<td colspan="7">MMSEA Section 111
Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Input Claim File Header Record – 2100 bytes</td>
</tr>
<tr>
<th>Field No.</th>
<th>Name</th>
<th>Size</th>
<th>Start Pos.</th>
<th>End Pos.</th>
<th>Data Type</th>
<th>Description</th>
</tr>
<tr>
<td>1</td>
<td>Record Identifier</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>Alpha-numeric</td>
<td>Must be 'NGCH'.

Required.</td>
</tr>
<tr>
<td>2</td>
<td>Section 111 Reporter ID</td>
<td>9</td>
<td>5</td>
<td>13</td>
<td>Numeric</td>
<td>COBC assigned Section 111Reporter ID #.

Required.</td>
</tr>
<tr>
<td>3</td>
<td>Section 111 Reporting File Type</td>
<td>7</td>
<td>14</td>
<td>20</td>
<td>Alpha-numeric</td>
<td>Must be 'NGHPCLM'.

Required.</td>
</tr>
<tr>
<td>4</td>
<td>File Submission Date</td>
<td>8</td>
<td>21</td>
<td>28</td>
<td>Numeric Date</td>
<td>Date file was transmitted to the COBC.

Format: CCYYMMDD

Required.</td>
</tr>
<tr>
<td>5</td>
<td>Reserved for Future Use</td>
<td>2072</td>
<td>29</td>
<td>2100</td>
<td>Alpha-numeric</td>
<td>Fill with spaces.</td>
</tr>
</table>

	MMSEA Section 111 Liability Insurance (Including Self-Insurance) No-Fault Insurance, Workers' Compensation Input Claim File Detail Record – 2100 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	Alpha-numeric	Social Security Number **Required if HICN not provided.** Fill with spaces if unknown and HICN provided.
6	Injured Party Last Name	40	37	76	Alpha-betic	Surname of Injured Party **Required.**
7	Injured Party First Name	30	77	106	Alpha-betic	Given or first name of Injured Party. **Required.**
8	Injured Party Middle Init	1	107	107	Alpha-betic	First letter of Injured Party middle name. Fill with space if unknown.
9	Injured Party Gender	1	108	108	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	109	116	Numeric Date	Date of Birth of Injured Party Format: CCYYMMDD **Required.**
11	Reserved for Future Use	20	117	136	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	137	144	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.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
13	Nature of Injury, Incident, Illness	2	145	146	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. 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 for New Claim Records Submitted on or after April 1, 2010.**
14	Reserved for Future Use	2	147	148	Alpha-numeric	Fill with spaces.
15	Cause of Injury, Incident, or Illness	2	149	150	Numeric	Workers' Compensation Insurance Organization (WCIO) Cause of Injury Code. Report the 2-digit code that corresponds to the cause of the injury. 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 for New Claim Records Submitted on or after April 1, 2010.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
16	Reserved for Future Use	2	151	152	Alpha-numeric	Fill with spaces.
17	State of Venue	2	153	154	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	Reserved for Future Use	1	155	155	Alpha-numeric	Fill with spaces.
19	ICD-9 Diagnosis Code 1	5	156	160	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, Body Part Code (Field 29), or Description of Injury/Illness (Field 34) is required. **Required for New Claim Records Submitted on or after April 1, 2010 if no Body Part Code 1 provided.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
20	Reserved for Future Use	3	161	163	Alpha-numeric	Fill with spaces.
21	ICD-9 Diagnosis Code 2	5	164	168	Alpha-numeric	See explanation for Field 19. Provide if available/applicable.
22	Reserved for Future Use	3	169	171	Alpha-numeric	Fill with spaces.
23	ICD-9 Diagnosis Code 3	5	172	176	Alpha-numeric	See explanation for Field 19. Provide if available/applicable.
24	Reserved for Future Use	3	177	179	Alpha-numeric	Fill with spaces.
25	ICD-9 Diagnosis Code 4	5	180	184	Alpha-numeric	See explanation for Field 19. Provide if available/applicable.
26	Reserved for Future Use	3	185	187	Alpha-numeric	Fill with spaces.
27	ICD-9 Diagnosis Code 5	5	188	192	Alpha-numeric	See explanation for Field 19. Provide if available/applicable.
28	Reserved for Future Use	2	193	194	Alpha-numeric	Fill with spaces.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
29	Body Part Code 1	3	195	197	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 1 (Field 19), Body Part Code 1, or Description of Injury/Illness (Field 34) is required. **Required for New Claim Records Submitted on or after April 1, 2010 if no ICD-9 Diagnosis Code 1 provided.**
30	Body Part Code 2	3	198	200	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	201	203	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	204	206	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	207	209	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	Description of Illness/Injury: (Temporary field available until April 1, 2010. Will be re-labeled for records submitted on or after April 1, 2010 as "Reserved for Future Use")	50	210	259	Alpha-numeric	Free-form text description of illness or injury. Include description of major body part injured (e.g. head, arm, leg, etc.) **Required if no Nature of Injury Code and a Cause of Injury Code and either ICD-9 Diagnosis Code 1 or Body Part Code 1 provided.** **NOTE: The Description for this Field will be changed for records submitted on or after April 1, 2010 to read "Fill With Spaces"**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
35	Product Liability Indicator	1	260	260	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.*
36	Product Generic Name	40	261	300	Alpha-numeric	Generic name of product alleged to be cause of injury, illness or incident. If no generic name applicable, supply brand name. **Required for New Claim Records Submitted on or after October 1, 2009 if Product Liability Indicator is Y and claim is a Mass Tort.** **Required for all New Claim Records Submitted on or after April 1, 2010 if Product Liability Indicator is Y.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
37	Product Brand Name	40	301	340	Alpha-numeric	Brand name of product alleged to be cause of injury, illness or incident. **Required for New Claim Records Submitted on or after October 1, 2009 if Product Liability Indicator is Y and claim is a Mass Tort.** **Required for all New Claim Records Submitted on or after April 1, 2010 if Product Liability Indicator is Y.**
38	Product Manufacturer	40	341	380	Alpha-numeric	Maker of product named in Fields 36 and/or 37 above. **Required for New Claim Records Submitted on or after October 1, 2009 if Product Liability Indicator is Y and claim is a Mass Tort.** **Required for all New Claim Records Submitted on or after April 1, 2010 if Product Liability Indicator is Y.**
39	Product Alleged Harm	200	381	580	Alpha-numeric	Free-form description of harm allegedly caused by product named in Fields 36 and/or 37 above. Required if Product Liability Indicator is Y.
40	Reserved for Future Use	20	581	600	Alpha-numeric	Fill with spaces.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
**Policyholder Information**
41	Policyholder Type	1	601	601	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.***
42	Policyholder Last Name	40	602	641	Alpha-betic	Surname of policyholder. **Required if Policy Type = I.**
43	Policyholder First Name	30	642	671	Alpha-betic	Given/First name of policyholder. **Required if Policy Type = I.**
44	DBA Name	70	672	741	Alpha-numeric	"Doing Business As" Name of organization/business policyholder. DBA Name or Legal Name is required for Policy Holder Type of O. **Required if Policy Type = O and Legal Name (Field 44) not provided.**
45	Legal Name	70	742	811	Alpha-numeric	Legal Name of organization/business policyholder. DBA Name or Legal Name is required for Policy Holder Type of O. **Required if Policy Type = O and DBA Name (Field 43) not provided.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
46	Self Insured Indicator	1	812	812	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).**
47	Reserved for Future Use	20	813	832	Alpha-numeric	Fill with spaces.
Plan Information						

48	Plan Insurance Type	1	833	833	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
49	TIN	9	834	842	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 Office Code/Site ID on the TIN Reference File. *Required.*
50	Office Code/Site ID	9	843	851	Alpha-Numeric	RRE-defined code to uniquely identify variations in insurer addresses/claim offices/Plan Contact Addresses. Defined by RRE. Used to uniquely specify different addresses associated with one TIN. If only one address will be used per reported TIN, leave blank. 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.*
51	Policy Number	30	852	881	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
52	Claim Number	30	882	911	Alpha-numeric	The unique claim identifier by which the primary plan identifies the claim. *Required.*
53	Plan Contact Department Name	70	912	981	Alpha-numeric	Name of department for the Plan Contact to which claim-related communication and correspondence should be sent. *Required.*
54	Plan Contact Last Name	40	982	1021	Alpha-numeric	Surname of individual that should be contacted at the Plan for claim-related communication and correspondence. *Optional.*
55	Plan Contact First Name	30	1022	1051	Alpha-numeric	Given or first name of individual that should be contacted at the Plan for claim-related communication and correspondence. *Optional.*
56	Plan Contact Phone	10	1052	1061	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
57	Plan Contact Phone Extension	5	1062	1066	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.
58	No-Fault Insurance Arrangement Indicator	1	1067	1067	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.**
59	Total No-Fault Insurance Limit	11	1068	1078	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 9's if not applicable. **Required if No-Fault Insurance Arrangement Indicator (Field 58) is 1 or 2.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
60	Specified Medicals Cap Amount In a Stand Alone or Independent No-Fault Insurance Policy	11	1079	1089	Numeric	Dollar amount of cap specified on medicals for a stand alone or independent no-fault insurance policy. *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 9's if not applicable. **Required if No-Fault Insurance Arrangement Indicator (Field 58) is 1.**
61	Exhaust Date for Total Amount for No-Fault Insurance	8	1090	1097	Numeric Date	Date on which limit was reached or benefits exhausted for Total No-Fault Insurance Limit (Field 59). Format: CCYYMMDD Fill with zeros if not applicable. **Required if No-Fault Insurance Arrangement Indicator (Field 58) is 1 or 2 and benefit limit reached.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
62	Exhaust Date for Specified Medicals Cap Amount in a Stand Alone or Independent No-Fault Insurance Policy	8	1098	1105	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 60). Format: CCYYMMDD Fill with zeros if not applicable. **Required if No-Fault Insurance Arrangement Indicator (Field 58) is 1 and benefit limit reached.**
63	Reserved for Future Use	20	1106	1125	Alpha-numeric	Fill with spaces
Injured Party's Attorney or Other Representative Information						
Attorney/Representative information required only if injured party has a representative.						
64	Injured Party Representative Indicator	1	1126	1126	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.**
65	Representative Last Name	40	1127	1166	Alpha-betic	Surname of representative. **Required if Injured Party has a representative.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
66	Representative First Name	30	1167	1196	Alpha-betic	Given or first name of representative. **Required if Injured Party has a representative.**
67	Representative Firm Name	70	1197	1266	Alpha-numeric	Representative's firm name. **Required on reports submitted on or after April 1, 2010 if Representative is associated with or a member of a firm.**
68	Representative TIN	9	1267	1275	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 if Injured Party has a representative.**
69	Representative Mailing Address Line 1	50	1276	1325	Alpha-numeric	First line of the mailing address for the representative named above. **Required if Injured Party has a representative.**
70	Representative Mailing Address Line 2	50	1326	1375	Alpha-numeric	Second line of the mailing address of the representative named above.
71	Representative City	30	1376	1405	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
72	Representative State	2	1406	1407	Alpha-numeric	US Postal abbreviation state code for the representative named above. **Required if Injured Party has a representative.**
73	Representative Mail Zip Code	5	1408	1412	Numeric	5-digit Zip Code for the representative named above. **Required if Injured Party has a representative.**
74	Representative Mail Zip+4	4	1413	1416	Numeric	4-digit Zip+4 code for the representative named above. If not applicable or unknown, fill with zeroes (0000).
75	Representative Phone	10	1417	1426	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.**
76	Representative Phone Extension	5	1427	1431	Alpha-numeric	Telephone extension number of representative named above. Fill with all spaces if unknown or not applicable.
77	Reserved for Future Use	20	1432	1451	Alpha-numeric	Fill with spaces.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
Settlement, Judgment, Award or Other Payment Information						
78	ORM Indicator	1	1452	1452	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.**
79	ORM Termination Date	8	1453	1460	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
80	TPOC Date	8	1461	1468	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 **Not required for the initial report of a claim reflecting ongoing payment responsibility. If ongoing payment responsibility ends due to a settlement, report the settlement date on the second (final) report for the ongoing case. Otherwise fill with all zeroes.** **Required for all other claim reports.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
81	TPOC Amount	11	1469	1479	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. When reporting claims reflecting ongoing payment responsibility, fill with zeroes unless the ongoing responsibility ended due to a settlement. 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
82	Funding Delayed Beyond TPOC Start Date	8	1480	1487	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.
83	Reserved for Future Use	20	1488	1507	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 84-97) 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.)						
84	Claimant 1 Relationship	1	1508	1508	Alpha-numeric	Relationship of the claimant to the injured party/Medicare beneficiary. Valid values: E = Estate F = Family O = Other Space = Not applicable (rest of the section will be ignored) Optional July 1, 2009 – March 31, 2010. **Required April 1, 2010 and subsequent if claimant is not the injured party.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
85	Claimant 1 TIN	9	1509	1517	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.**
86	Claimant 1 Last Name	40	1518	1557	Alpha-betic	Surname of Claimant 1. **Required if claimant is not the injured party.**
87	Claimant 1 First Name	30	1558	1587	Alpha-betic	Given/First name of Claimant 1. **Required if claimant is not the injured party.**
88	Claimant 1 Middle Initial	1	1588	1588	Alpha-betic	First letter of Claimant 1's middle name.
89	Claimant 1 Mailing Address Line 1	50	1589	1638	Alpha-numeric	First line of the mailing address for the claimant named above. **Required if claimant is not the injured party.**
90	Claimant 1 Mailing Address Line 2	50	1639	1688	Alpha-numeric	Second line of the mailing address of the claimant named above.
91	Claimant City	30	1689	1718	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
92	Claimant 1 State	2	1719	1720	Alpha-betic	US Postal abbreviation state code for the claimant named above. **Required if claimant is not the injured party.**
93	Claimant 1 Zip	5	1721	1725	Numeric	5-digit Zip Code for the claimant named above. **Required if claimant is not the injured party.**
94	Claimant 1 Zip+4	4	1726	1729	Numeric	4-digit Zip+4 code for the claimant named above. If not applicable or unknown, fill with zeroes (0000).
95	Claimant 1 Phone	10	1730	1739	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.**
96	Claimant 1 Phone Extension	5	1740	1744	Alpha-numeric	Telephone extension number of the claimant named above. Fill with all spaces if unknown or not applicable.
97	Reserved for Future Use	20	1745	1764	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 98-111) with spaces if not supplying Claimant 1 representative information.
98	Claimant 1 (C1) Representative Indicator	1	1765	1765	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.**
99	C1 Representative Last Name	40	1766	1805	Alpha-betic	Surname of C1 representative. **Required if Claimant 1 has a representative.**
100	C1 Representative First Name	30	1806	1835	Alpha-betic	Given/First name of C1 representative. **Required if Claimant 1 has a representative.**
101	C1 Representative Firm Name	70	1836	1905	Alpha-numeric	Representative's firm name. **Required on reports April 1, 2010 and subsequent if C1 Representative is associated with or a member of a firm.**

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
102	C1 Representative TIN	9	1906	1914	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.**
103	C1 Representative Mail Address 1	50	1915	1964	Alpha-numeric	First line of the mailing address for the C1 representative named above. **Required if Claimant 1 has a representative.**
104	C1 Representative Mailing Address 2	50	1965	2014	Alpha-numeric	Second line of the mailing address of the C1 representative named above.
105	C1 Representative Mailing City	30	2015	2044	Alpha-betic	Mailing address city for the C1 representative named above. **Required if Claimant 1 has a representative.**
106	C1 Representative State	2	2045	2046	Alpha-betic	US Postal abbreviation state code for the C1 representative named above. **Required if Claimant 1 has a representative.**
107	C1 Representative Zip	5	2047	2051	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
108	C1 Representative Zip+4	4	2052	2055	Numeric	4-digit Zip+4 code for the C1 representative named above. If not applicable or unknown, fill with zeroes (0000).
109	C1 Representative Phone	10	2056	2065	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.**
110	C1 Representative Phone Extension	5	2066	2070	Alpha-numeric	Telephone extension number of the C1 representative named above. Fill with all spaces if unknown or not applicable.
111	Reserved for Future Use	30	2071	2100	Alpha-numeric	Fill with spaces.

	MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Input Claim File Auxiliary Record – 2100 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	40	36	75	Alpha-betic	Must match the value in this field on the Detail Claim Record. **Required.**
6	Injured Party First Name	30	76	105	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	106	106	Alpha-numeric	Relationship of the claimant to the injured party/Medicare beneficiary. Valid values: E = Estate F = Family O = Other Space = Not applicable (rest of the section will be ignored) **Required on reports April 1, 2010 and subsequent.**
8	Claimant 2 TIN	9	107	115	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	40	116	155	Alpha-betic	Surname of Claimant 2. **Required.**
10	Claimant 2 First Name	30	156	185	Alpha-betic	Given/First name of Claimant 2. **Required.**
11	Claimant 2 Middle Initial	1	186	186	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	50	187	236	Alpha-numeric	First line of the mailing address for Claimant 2 named above. **Required.**
13	Claimant 2 Mailing Address Line 2	50	237	286	Alpha-betic	Second line of the mailing address for Claimant 2 named above.
14	Claimant 2 City	30	287	316	Alpha-betic	Mailing address city for Claimant 2 named above. **Required.**
15	Claimant 2 State	2	317	318	Alpha-betic	US Postal abbreviation state code for Claimant 2 named above. **Required.**
16	Claimant 2 Zip	5	319	323	Numeric	5-digit Zip Code for Claimant 2 named above. **Required.**
17	Claimant 2 Zip+4	4	324	327	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	328	337	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	338	342	Alpha-numeric	Telephone extension number of Claimant 2 named above. Fill with all spaces if unknown or not applicable.
20	Reserved for Future Use	20	343	362	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	363	363	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	40	364	403	Alpha-betic	Surname of C2 attorney or representative. **Required if Claimant 2 has a representative.**
23	C2 Representative First Name	30	404	433	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	70	434	503	Alpha-numeric	Representative's firm name. **Required on reports April 1, 2010 and subsequent if C2 Representative is associated with or a member of a firm.**
25	C2 Representative TIN	9	504	512	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	50	513	562	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	50	563	612	Alpha-numeric	Second line of the mailing address of the C2 representative named above.
28	C2 Representative City	30	613	642	Alpha-betic	Mailing address city for the C2 representative named above. **Required if Claimant 2 has a representative.**
29	C2 Representative State	2	643	644	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	645	649	Numeric	5-digit Zip Code for the C2 representative named above. **Required if Claimant 2 has a representative.**
31	C2 Representative Zip+4	4	650	653	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	654	663	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	664	668	Alpha-numeric	Telephone extension number of the C2 representative named above. Fill with all spaces if unknown or not applicable.
34	Reserved for Future Use	20	669	688	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	689	689	Alpha-numeric	Relationship of the claimant to the injured party/Medicare beneficiary. Valid values: E = Estate F = Family O = Other Space = Not applicable (rest of the section will be ignored)
36	Claimant 3 TIN	9	690	698	Numeric	
37	Claimant 3 Last Name	40	699	738	Alpha-betic	
38	Claimant 3 First Name	30	739	768	Alpha-betic	
39	Claimant 3 Middle Initial	1	769	769	Alpha-betic	
40	Claimant 3 Mailing Address Line 1	50	770	819	Alpha-numeric	
41	Claimant 3 Mailing Address Line 2	50	820	869	Alpha-numeric	
42	Claimant 3 City	30	870	899	Alpha-betic	
43	Claimant 3 State	2	900	901	Alpha-betic	
44	Claimant 3 Zip	5	902	906	Numeric	
45	Claimant 3 Zip+4	4	907	910	Numeric	

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
46	Claimant 3 Phone	10	911	920	Numeric	
47	Claimant 3 Phone Extension	5	921	925	Alpha-numeric	
48	Reserved for Future Use	20	926	945	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	946	946	Alpha-numeric	
50	C3 Representative Last Name	40	947	986	Alpha-betic	
51	C3 Representative First Name	30	987	1016	Alpha-betic	
52	C3 Representative Firm Name	70	1017	1086	Alpha-numeric	
53	C3 Representative TIN	9	1087	1095	Numeric	
54	C3 Representative Mailing Address Line 1	50	1096	1145	Alpha-numeric	
55	C3 Representative Mailing Address Line 2	50	1146	1195	Alpha-numeric	
56	C3 Representative City	30	1196	1225	Alpha-betic	

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
57	C3 Representative State	2	1226	1227	Alpha-betic	
58	C3 Representative Zip	5	1228	1232	Numeric	
59	C3 Representative Zip+4	4	1233	1236	Numeric	
60	C3 Representative Phone	10	1237	1246	Numeric	
61	C3 Representative Phone Extension	5	1247	1251	Alpha-numeric	
62	Reserved for Future Use	20	1252	1271	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	1272	1272	Alpha-numeric	
64	Claimant 4 TIN	9	1273	1281	Numeric	
65	Claimant 4 Last Name	40	1282	1321	Alpha-betic	
66	Claimant 4 First Name	30	1322	1351	Alpha-betic	
67	Claimant 4 Middle Initial	1	1352	1352	Alpha-betic	
68	Claimant 4 Mailing Address Line 1	50	1353	1402	Alpha-numeric	
69	Claimant 4 Mailing Address Line 2	50	1403	1452	Alpha-numeric	
70	Claimant 4 City	30	1453	1482	Alpha-betic	

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
71	Claimant 4 State	2	1483	1484	Alpha-betic	
72	Claimant 4 Zip	5	1485	1489	Numeric	
73	Claimant 4 Zip+4	4	1490	1493	Numeric	
74	Claimant 4 Phone	10	1494	1503	Numeric	
75	Claimant 4 Phone Extension	5	1504	1508	Alpha-numeric	
76	Reserved for Future Use	20	1509	1528	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	1529	1529	Alpha-betic	
78	C4 Representative Last Name	40	1530	1569	Alpha-betic	
79	C4 Representative First Name	30	1570	1599	Alpha-betic	
80	C4 Representative Firm Name	70	1600	1669	Alpha-numeric	
81	C4 Representative TIN	9	1670	1678	Numeric	
82	C4 Representative Mailing Address Line 1	50	1679	1728	Alpha-numeric	
83	C4 Representative Mailing Address Line 2	50	1729	1778	Alpha-numeric	
84	C4 Representative City	30	1779	1808	Alpha-betic	
85	C4 Representative State	2	1809	1810	Alpha-betic	

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
86	C4 Representative Zip	5	1811	1815	Numeric	
87	C4 Representative Zip+4	4	1816	1819	Numeric	
88	C4 Representative Phone	10	1820	1829	Numeric	
89	C4 Representative Phone Extension	5	1830	1834	Alpha-numeric	
90	Reserved for Future Use	266	1835	2100	Alpha-numeric	Fill with spaces.

MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Input Claim File Trailer Record – 2100 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	Reserved for Future Use	2065	36	2100	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 – 2100 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	Reserved for Future Use	2072	29	2100	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 – 2100 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 49 of each Detail Claim Record. Used in conjunction with the Site ID reported in Field 50 of the Detail Claim Record. Also know as the Employer Identification Number (EIN). Each TIN/Site ID combination reported in Fields 49 and 50 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	Office Code/Site ID	9	23	31	Alpha-Numeric	RRE-defined code to uniquely identify variations in insurer addresses/claim offices/Plan Contact Addresses as reported in Field 50 of each Detail claim Record. Used in conjunction with the TIN reported in Field 49 of the Detail Claim record to uniquely specify different addresses associated with one TIN. If only one address will be used per reported TIN, leave blank. Each TIN/Site ID combination reported in Fields 49 and 50 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	70	32	101	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	50	102	151	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	50	152	201	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.
8	TIN/Site/ID City	30	202	231	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	232	233	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	234	238	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	239	242	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	Reserved for Future Use	1858	243	2100	Alpha-numeric	Fill with spaces.

Field No.	Name	Size	Start Pos.	End Pos.	Date Type	Description
**MMSEA Section 111** **Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers'** **Compensation TIN Reference File Trailer Record – 2100 bytes**
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	Reserved for Future Use	2065	36	2100	Alpha-numeric	Fill with spaces.

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

Claim Response File Layout

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Description
MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Header Record – 400 bytes						
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 for Future Use	372	29	400	Alpha-numeric	Contains all spaces.

	MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Detail Record – 400 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	40	37	76	Alpha-betic	As supplied by RRE on input record.
7	Submitted Injured Party First Name	30	77	106	Alpha-betic	As supplied by RRE on input record.
8	Submitted Injured Party Middle Init	1	107	107	Alpha-betic	As supplied by RRE on input record.
9	Submitted Injured Party Gender	1	108	108	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	109	116	Numeric Date	As supplied by RRE on input record.
11	Submitted Plan TIN	9	117	125	Numeric	As supplied by RRE on input record.
12	Submitted Plan Office Code/Site ID	9	126	134	Alpha-Numeric	As supplied by RRE on input record.
13	Reserved for Future Use	20	135	154	Alpha-numeric	Filled with spaces.
14	Applied Injured Party HICN	12	155	166	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	167	175	Numeric	Social Security Number (SSN) of Injured Party if confirmed to be a Medicare beneficiary. COBC supplied.
16	Applied Injured Party Last Name	40	176	215	Alpha-betic	Injured Party Last Name if confirmed to be a Medicare beneficiary. COBC supplied.
17	Applied Injured Party First Name	30	216	245	Alpha-betic	Injured Party First Name if confirmed to be a Medicare beneficiary. COBC supplied.
18	Applied Injured Party Middle Initial	1	246	246	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	247	247	Numeric	Sex of Injured Party if confirmed to be a Medicare beneficiary. COBC supplied. 1 - Male 2 - Female
20	Applied Injured Party DOB	8	248	255	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	256	263	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	264	271	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	272	272	Alpha-numeric	Applied Medicare Secondary Payer (MSP) Type. D = No-Fault E = Workers' Compensation L = Liability COBC supplied.
24	Reserved for Future Use	20	273	292	Alpha-numeric	Filled with spaces.
25	Applied Disposition Code	2	293	294	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	295	299	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	300	304	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	305	309	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	310	314	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	315	319	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	320	324	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	325	329	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	330	334	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	335	339	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	340	344	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	Reserved for Future Use	56	345	400	Alpha-numeric	Filled with spaces.

	MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, Workers' Compensation Claim Response File Trailer Record – 400 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	Reserved for Future Use	365	36	400	Alpha-numeric	Filled with spaces.