ERRP Secure Website Claim List Layouts

Data Type Requirement:

If 'A', must be alphabetic character(s).
If 'N', must be numeric character(s).
If 'A/N', must be alphabetic, numeric, or special characters (unless otherwise noted), or a combination of alphabetic and numeric character(s).

Required = Field shall be completed with valid values as described in the "Description/Value" column.
Situational = Field shall be completed with valid values in certain situations as described in the "Description/Value" column.
Optional = Field is not required and may be left blank if not available/not applicable.

For detailed information on the Claim List Response File Reason Codes associated with each Claim List field, refer to the "Claim List Response File Reason Codes" column of the Claim List Layout tables. Select a Reason Code link to jump directly to the applicable Reason Code description row in the Claim List Response File Reason Codes table. After reading the "What It Means" and "What You Should Do" information for the Reason Code, return to the applicable Claim List Layout table by selecting a Claim List Layout field number link from the "Claim List Layouts Navigation" column.

ERRP Secure Website Professional Layout

Field No.	Name	Max Size	Data Type	Required/ Situational/ Optional	Description/Value	Claim List Response File Reason Codes
Professional Claim Record						
FH01	Record Type	2	A/N	R	DP = Professional	002 026 Go to CLRF Reason Codes
FH02	Application ID	10	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.	008 Go to CLRF Reason Codes
FH03	Plan Year Start Date	8	N	R	Date the Plan Year begins provided in CCYYMMDD format. This date is specific to the Application ID.	008 Go to CLRF Reason Codes

HP02	Member ID	30	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 004 009 011 Go to CLRF Reason Codes
HP03	Member Group ID	20	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 011 Go to CLRF Reason Codes
HP04	Claim Number	38	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the Plan Sponsor. For additional information about unique ID, please visit Common Question 1100-3.	001 011 024 033 Go to CLRF Reason Codes
HP05	Derived Claim Indicator	1	A	R	Code value indicating whether or not a given claim was paid as a fee for service claim (Actual Claim) or paid under a capitated arrangement (Derived Claim). Y = Derived Claim N = Actual Claim For additional information about derived claims, please visit Common Question 1100-5.	001 010 011 Go to CLRF Reason Codes
HP06	Plan Paid Date	8	N	R	Date claim system adjudicated or processed the claim for payment. It is acceptable to have different Plan Paid Dates on different lines within the same claim. CCYYMMDD	005 011 Go to CLRF Reason Codes
HP07	Member Date of Birth	8	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.	004 005 011 023 Go to CLRF Reason Codes

HP08	Member Gender	1	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.	003 004 010 011 023 Go to CLRF Reason Codes
HP09	Cost Paid By Early Retiree	9	N	O	The aggregated actual costs for health benefits paid by approved Early Retirees for a given claim. Cannot be negative. Decimal must not be submitted. 7v2 (Example: $543.21 = 54321) *Amount must be the full amount the member paid for the claim (not net of rebates). When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. If a Plan Sponsor is not requesting reimbursement for Costs Paid by an Early Retiree, this field must contain zero.	003 011 025 Go to CLRF Reason Codes
DP05	Claim Line Item Number	3	N	R	Line Number identifying the Service line associated with a claim. For additional information about Assigning Claim Line Item Number, please visit Common Question 1100-2.	003 011 Go to CLRF Reason Codes
DP06	From Date of Service	8	N	R	Service Begin Date, Incurred date of claim CCYYMMDD	005 011 012 034 Go to CLRF Reason Codes
DP07	To Date of Service	8	N	R	Service Ending Date CCYYMMDD	005 011 Go to CLRF Reason Codes
DP08	Place of Service	2	A/N	O	Code value used to identify the location/facility where the service was rendered. Two-digit codes for health care professional claims to indicate the setting in which a service was provided.	011 Go to CLRF Reason Codes

DP09	Procedure Code	30	A/N	R	Code value used to designate the specific health interventions taken by medical professionals. Must be a valid HCPCS/CPT/NDC code. Cannot be less than 5 contiguous characters and must not contain special characters or spaces within the 5 contiguous characters. "XXXXX" is a valid alpha value for the Procedure Code (DP09) field when reporting bundled Professional claim detail lines. The bundled claim detail line must be followed by at least one subsequent claim detail line for which all the following conditions are true: valid value (not "XXXXX") entered in the Procedure Code (DP09) field and value entered in the Item Plan Paid Amount (DP24) field equal to zero. For information on how to report bundled claims, please visit Common Question 1100-23.	001 007 011 013 014 029 Go to CLRF Reason Codes
DP10	Procedure Code Modifier1	2	A/N	O	Code value used to provide further information about the service being performed.	011 Go to CLRF Reason Codes
DP11	Procedure Code Modifier2	2	A/N	O	Code value used to provide further information about the service being performed.	011 Go to CLRF Reason Codes
DP12	Procedure Code Modifier3	2	A/N	O	Code value used to provide further information about the service being performed.	011 Go to CLRF Reason Codes
DP13	Procedure Code Modifier4	2	A/N	O	Code value used to provide further information about the service being performed.	011 Go to CLRF Reason Codes
DP14	ICD Code Qualifier	1	N	R	Code value used to identify which version of ICD is being utilized. 1 = ICD-9 code 2 = ICD-10 code	003 010 011 Go to CLRF Reason Codes

DP15	Principal Diagnosis Code	7	A/N	R	Primary diagnosis code associated with the Member's condition. Must be a valid ICD code. If the Principal Diagnosis Code field is not available, do not submit this claim. Please visit Common Question 1100-11 for additional information. Other than trailing spaces and/or one decimal, special characters are not allowed. The presence of the decimal is optional for ICD9; however, the decimal is not allowed for ICD10. ICD9 code length must be at least 3 contiguous characters and no greater than 5 contiguous characters (when submitted without a decimal) or at least 4 contiguous characters and no greater than 6 contiguous characters (when submitted with a decimal). ICD10 code length must be at least 3 contiguous characters and no greater than 7 contiguous characters.	001 011 013 014 029 Go to CLRF Reason Codes
DP16	Other Diagnosis Code2	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DP15. Not allowed if primary is blank.	011 013 014 029 Go to CLRF Reason Codes
DP17	Other Diagnosis Code3	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DP15. Not allowed if primary is blank.	011 013 014 029 Go to CLRF Reason Codes
DP18	Other Diagnosis Code4	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DP15. Not allowed if primary is blank.	011 013 014 029 Go to CLRF Reason Codes

DP19	Quantity Qualifier	2	A/N	O	Code value used to identify the type of measurement used in the Unit Quantity field. DA = Days DH = Miles UN = Units MJ = Minutes WK = Weeks MO = Months Q1 = Quarter(Time) YR = Year LB = Pounds GM = Gram F2 = International Unit 01 = Actual Pounds ME = Milligram ML = Milliliter EA = Each 99 = Other	011 Go to CLRF Reason Codes
DP20	Unit Quantity	9	N	O	Quantity of services/product delivered. If a value is provided, it must be numeric. Decimal must not be submitted. 6v3 (Example: 9.999 = 9999) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field.	003 011 Go to CLRF Reason Codes
DP21	Rendering Provider ID Qualifier	2	A/N	R	Code value used to identify the type of Provider ID reported in the Rendering Provider ID field. XX = NPI 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other Please visit Common Question 1100-13 for additional information.	001 010 011 Go to CLRF Reason Codes
DP22	Rendering Provider ID	80	A/N	R	ID of the Provider/Supplier rendering the services to the Member. If the Rendering Provider/Supplier ID is not available, Plan Sponsors may submit the Billing Provider ID number instead. Please visit Common Question 1100-12 for additional information.	001 011 021 027 028 Go to CLRF Reason Codes

DP23	Service Location Zip Code	5	N	R	US Zip Code of the location where service was rendered. If the Service Location Zip Code is not available, submit the Rendering provider or Billing provider zip code. If neither of those is available, but the Plan Sponsor is certain the item or service was provided in the U.S., please contact the ERRP Center. Please visit Common Question 1100-14 for additional information. Only provide 5 bytes for this field.	003 011 029 Go to CLRF Reason Codes
DP24	Item Plan Paid Amount	9	N	R	The dollar amount paid by the Plan for this claim item. Cannot be negative. For additional information, please visit Common Question 1100-1. Cannot be blank. Decimal must not be submitted. May be zero if service line supports bundled service or claim. May be zero if Early Retiree paid and the Plan did not. Otherwise, if the Item Plan Paid Amount is not available, omit this claim line from the claim list. For additional information, please visit Common Question 1100-7. 7v2 (Example: $543.21 = 54321) *Amount must be the full amount the plan paid for the claim line (not net of rebates). In contrast, the Cost Paid By Plan amount entered in the Cost Summary Report in the SWS is net of rebates. When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. For additional information on reporting adjusted claims, please visit Common Question 1100-4	003 011 999 Go to CLRF Reason Codes

ERRP Secure Website Institutional Layout

Field No.	Name	Max Size	Data Type	Required/ Situational / Optional	Description/Value	Claim List Response File Reason Codes
Institutional Claim Detail Record						
FH01	Record Type	2	A/N	R	DI = Institutional	002 026 Go to CLRF Reason Codes
FH02	Application ID	10	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.	008 Go to CLRF Reason Codes
FH03	Plan Year Start Date	8	N	R	Date the Plan Year begins provided in CCYYMMDD format. This date is specific to the Application ID field.	008 Go to CLRF Reason Codes
HI02	Member ID	30	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 004 009 011 Go to CLRF Reason Codes
HI03	Member Group ID	20	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 011 Go to CLRF Reason Codes
HI04	Claim Number	38	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the Plan Sponsor. For additional information about unique ID, please visit Common Question 1100-3.	001 011 024 033 Go to CLRF Reason Codes

HI05	Derived Claim Indicator	1	A	R	Code value indicating whether or not a given claim was paid as a fee for service claim (Actual Claim) or paid under a capitated arrangement (Derived Claim). Y = Derived Claim N = Actual Claim For additional information about derived claims, please visit Common Question 1100-5.	001 010 011 Go to CLRF Reason Codes
HI06	Plan Paid Date	8	N	R	Date claim system adjudicated or processed the claim for payment. It is acceptable to have different Plan Paid Dates on different lines within the same claim. CCYYMMDD	005 011 Go to CLRF Reason Codes
HI07	Member Date of Birth	8	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.	004 005 011 023 Go to CLRF Reason Codes
HI08	Member Gender	1	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.	003 004 010 011 023 Go to CLRF Reason Codes
HI09	Cost Paid By Early Retiree	9	N	O	The aggregated actual costs for health benefits paid by approved Early Retirees for a given claim. Cannot be negative Decimal must not be submitted. 7v2 (Example: $543.21 = 54321) *Amount must be the full amount the member paid for this claim (not net of rebates). When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. If a Plan Sponsor is not requesting reimbursement for Costs Paid by an Early Retiree, this field must contain zero.	003 011 025 Go to CLRF Reason Codes

HI10	Type of Bill	3	A/N	R	NUBC Code value which identifies the specific type of bill for institutional claims. Typically for industry standard, Type of Bill is a four byte field, with the first byte being a leading zero. For ERRP purposes it is a three byte field; drop the leading zero (first byte). For ERRP, the first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence. If the Type of Bill information is available for your Institutional claims, report the correct Type of Bill code. Please visit Common Question 1100-9 for additional information.	001 010 011 023 Go to CLRF Reason Codes
HI11	Facility Provider ID Qualifier	2	A/N	R	Code value that defines the type of Provider ID reported in the Facility Provider ID field. XX = NPI 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other If the Provider ID Qualifier field is not available, please visit Common Question 1100-13 for additional information.	001 010 011 023 Go to CLRF Reason Codes
HI12	Facility Provider ID	80	A/N	R	ID of the Facility where item/service was provided. If the Facility Provider ID number is not available, Plan Sponsor may submit the Billing Provider ID number of the provider or supplier that furnished the item or service. Please visit Common Question 1100-12 for additional information.	001 011 021 023 027 028 Go to CLRF Reason Codes
DI05	Claim Line Item Number	3	N	R	Line Number identifying the Service line associated with a claim. A claim must contain at least one service line. For additional information about Assigning Claim Line Item Number, please visit Common Question 1100-2.	003 011 Go to CLRF Reason Codes
DI06	Admission Date	8	N	R	Date admitted to facility for institutional claims. For non-acute care claims, if no Admission Date is available populate this field with the From Date of Service (DI07). CCYYMMDD Admission Date (DI06) is used as Incurred Date when Type of Bill (HI10) is "999" or starts with "11". Incurred date must fall within ERRP Eligibility dates for the plan year.	005 011 012 034 Go to CLRF Reason Codes

DI07	From Date of Service	8	N	R	Service Begin Date CCYYMMDD From Date of Service (DI07) is used as Incurred Date when Type of Bill (HI10) begins with a valid value other than “11”or “999” - valid value includes "000". Incurred date must fall within ERRP Eligibility dates for the plan year.	005 011 012 034 Go to CLRF Reason Codes
DI08	To Date of Service	8	N	R	Service Ending Date CCYYMMDD	005 011 Go to CLRF Reason Codes
DI09	ICD Code Qualifier	1	N	R	Code value used to identify which version of ICD is being utilized. 1 = ICD-9 code 2 = ICD-10 code	003 010 011 Go to CLRF Reason Codes
DI10	Principal Diagnosis Code	7	A/N	R	Primary diagnosis code associated with the Member’s condition. Must be a valid ICD code. If the Principal Diagnosis Code field is not available, please visit Common Question 1100-11 for additional information. Other than trailing spaces and/or one decimal, special characters are not allowed. The presence of the decimal is optional for ICD9; however, the decimal is not allowed for ICD10. ICD9 code length must be at least 3 contiguous characters and no greater than 5 contiguous characters (when submitted without a decimal) or at least 4 contiguous characters and no greater than 6 contiguous characters (when submitted with a decimal). ICD10 code length must be at least 3 contiguous characters and no greater than 7 contiguous characters (when submitted without a decimal).	001 011 013 014 029 Go to CLRF Reason Codes
DI11	Other Diagnosis Code	7	A/N	O	Other diagnosis code associated with the Member’s condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.	011 013 014 029 Go to CLRF Reason Codes

DI12	Other Diagnosis Code2	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.	011 013 014 029 Go to CLRF Reason Codes
DI13	Other Diagnosis Code3	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.	011 013 014 029 Go to CLRF Reason Codes
DI14	Other Diagnosis Code4	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.	011 013 014 029 Go to CLRF Reason Codes
DI15	Other Diagnosis Code5	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.	011 013 014 029 Go to CLRF Reason Codes

DI16	Principal ICD Procedure Code	7	A/N	S	Principal procedure performed within an institutional setting. Required only when procedure is performed. A valid ICD Principal Procedure Code, Revenue Code, or Procedure Code is required on each service item detail line. One, two, or all three fields may be populated. For additional information, please visit Common Question 1100-10. Other than trailing spaces and/or one decimal, special characters are not allowed. The presence of the decimal is optional for ICD9; however, the decimal is not allowed for ICD10. ICD9 code must be at least 3 contiguous characters and no greater than 4 contiguous characters (without decimals) or at least 4-contiguous characters and no greater than 5 contiguous characters (with decimals). ICD10 code must be 7 contiguous characters in length without a decimal. For information on how to report bundled claims, please visit Common Question 1100-23.	011 013 014 029 Go to CLRF Reason Codes
DI17	Other ICD Procedure Code	7	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.	011 013 014 015 029 Go to CLRF Reason Codes
DI18	Other ICD Procedure Code2	7	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.	011 013 014 015 029 Go to CLRF Reason Codes

DI19	Other ICD Procedure Code3	7	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.	011 013 014 015 029 Go to CLRF Reason Codes
DI20	Other ICD Procedure Code4	7	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.	011 013 014 015 029 Go to CLRF Reason Codes
DI21	Other ICD Procedure Code5	7	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.	011 013 014 015 029 Go to CLRF Reason Codes

DI22	Revenue Code	4	A/N	S	NUBC Code value that identifies the specific cost center related to the service for institutional claims. Individual services that contain Revenue Codes should be reported as documented in the claim. Revenue Code "0001" is an invalid code for ERRP purposes and a Claim List with this code will be rejected. A 4 byte code is strongly encouraged. However, if necessary, you may drop a leading zero (first character) and submit a 3 byte code. A code containing fewer than 3 bytes will cause an error. A valid ICD Principal Procedure Code, Revenue Code, or Procedure Code is required on each service item detail line. One, two, or all three fields may be populated. "XXXX" is the only valid alpha value for the Revenue Code (DI22) field. "XXXX" is a valid value when reporting bundled Institutional claim detail lines. The bundled claim detail line must be followed by at least one subsequent claim detail line for which all the following conditions are true: valid value entered in the Principal ICD Procedure Code (DI16) field; or valid value (not "XXXX") entered in the Revenue Code (DI22) field; or valid value entered in the Procedure Code (DI23) field; and value entered in the Item Plan Paid Amount (DI31) field equal to zero. For information on how to report bundled claims, please visit Common Question 1100-23.	007 010 011 013 016 029 Go to CLRF Reason Codes
DI23	Procedure Code	30	A/N	S	Code value used to designate the specific health interventions taken by medical professionals. Must be a valid HCPCS/HIPPS/CPT/NDC code. Cannot be less than 5 contiguous characters and must not contain special characters or spaces within the 5 contiguous characters. A valid ICD Principal Procedure Code, Revenue Code, or Procedure Code is required on each service item detail line. One, two, or all three fields may be populated. For information on how to report bundled claims, please visit Common Question 1100-23.	011 013 014 029 Go to CLRF Reason Codes
DI24	Procedure Code Modifier1	2	A/N	O	Code value used to provide further information about the service being performed.	011 Go to CLRF Reason Codes

DI25	Procedure Code Modifer2	2	A/N	O	Code value used to provide further information about the service being performed.	011 Go to CLRF Reason Codes
DI26	Procedure Code Modifier3	2	A/N	O	Code value used to provide further information about the service being performed.	011 Go to CLRF Reason Codes
DI27	Procedure Code Modifier4	2	A/N	O	Code value used to provide further information about the service being performed.	011 Go to CLRF Reason Codes
DI28	Quantity Qualifier	2	A/N	O	Code value used to identify the type of measurement used in the Unit Quantity field. DA = Days DH = Miles UN = Units MJ = Minutes WK = Weeks MO = Months Q1 = Quarter(Time) YR = Year LB = Pounds GM = Grams F2 = International Unit 01 = Actual Pounds ME = Milligram ML = Milliliter EA = Each 99= Other	011 Go to CLRF Reason Codes
DI29	Unit Quantity	9	N	O	Quantity of services/product delivered. If a value is provided, it must be numeric. Decimal must not be submitted. 6v3 (Example: 9.999 = 9999) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field.	003 011 Go to CLRF Reason Codes

DI30	Service Location Zip Code	5	N	R	US Zip Code of the location where service was rendered. If the Service Location Zip Code is not available, submit the Rendering provider or Billing provider zip code. If neither of those is available, but the Plan Sponsor is certain the item or service was provided in the U.S., contact the ERRP Center. Please visit Common Question 1100-14 for additional information. Only submit 5 bytes for this field.	003 011 029 Go to CLRF Reason Codes
DI31	Item Plan Paid Amount	9	N	R	The dollar amount paid by the Plan for this claim item. 7v2 (Example: $543.21 =54321) Cannot be negative. For additional information, please visit Common Question 1100-1. Cannot be blank. Decimal must not be submitted. May be zero if service line supports bundled service or claim. May be zero if Early Retiree paid and the Plan did not. Otherwise, if the Item Plan Paid Amount is not available, omit this claim line from the Claim List. For additional information, please visit Common Question 1100-7. *Amount must be the full amount the plan paid for the claim line (not net of rebates). In contrast, the Cost Paid By Plan amount entered into the Cost Summary Report in the SWS is net of rebates. When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. For information on reporting adjusted claims, please visit Common Question 1100-4.	003 011 999 Go to CLRF Reason Codes

ERRP Secure Website Prescription Layout

Field No.	Name	Max Size	Data Type	Required/ Situational/ Optional	Description/Value	Claim List Response File Reason Codes
Prescription Claim Detail Record						
FH01	Record Type	2	A/N	R	DX = Prescription	002 026 Go to CLRF Reason Codes
FH02	Application ID	10	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.	008 Go to CLRF Reason Codes
FH03	Plan Year Start Date	8	N	R	Date the Plan Year begins, provided in CCYYMMDD format. This date is specific to the Application ID field.	008 Go to CLRF Reason Codes
HX02	Member ID	30	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 004 009 011 Go to CLRF Reason Codes
HX03	Member Group ID	20	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 011 Go to CLRF Reason Codes
HX04	Claim Number	38	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the Plan Sponsor. For additional information about unique ID, please visit Common Question 1100-3.	001 011 024 033 Go to CLRF Reason Codes

HX05	Derived Claim Indicator	1	A	R	Code value indicating whether or not a given claim was paid as a fee for service claim (Actual Claim) or paid under a capitated arrangement (Derived Claim). Y = Derived Claim N = Actual Claim For additional information about derived and not derived claims, please visit Common Question 1100-5.	001 010 011 Go to CLRF Reason Codes
HX06	Plan Paid Date	8	N	R	Date claim system adjudicated or processed the claim for payment. It is acceptable to have different Plan Paid Dates on different lines within the same claim. CCYYMMDD	005 011 Go to CLRF Reason Codes
HX07	Member Date of Birth	8	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.	004 005 011 023 Go to CLRF Reason Codes
HX08	Member Gender	1	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.	003 004 010 011 023 Go to CLRF Reason Codes
HX09	Cost Paid By Early Retiree	9	N	O	*The aggregated actual costs for health benefits paid by approved Early Retirees for a given claim. Cannot be negative. Decimal must not be submitted. 7v2 (Example: $543.21 = 54321) *Amount must be the full amount the member paid for this claim (not net of rebates). When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. If a Plan Sponsor is not requesting reimbursement for Costs Paid by an Early Retiree, this field must contain zero.	003 011 025 Go to CLRF Reason Codes

HX10	Prescription Service Provider ID Qualifier	2	A/N	R	Code value that defines the type of Service Provider ID reported in the Prescription Service Provider ID field. XX = NPI 07 = NABP 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other Please visit Common Question 1100-13 for additional information.	001 010 011 023 Go to CLRF Reason Codes
HX11	Prescription Service Provider ID	80	A/N	R	ID of the Pharmacy or Supplier for prescription claims. In most cases, will be the NABP number. If the Pharmacy or Supplier Provider ID field is not available, submit the Billing Provider ID number of the provider or supplier that furnished the item or service. Please visit Common Question 1100-12 for additional information.	001 011 021 023 027 028 Go to CLRF Reason Codes
DX05	Claim Line Item Number	3	N	R	Line Number identifying the Service line within a claim. A claim must contain at least one service line. For additional information about Assigning Claim Line Item Number, please visit Common Question 1100-2.	003 011 Go to CLRF Reason Codes
DX06	Filled Date	8	N	R	Date Prescription was filled for prescription claims. CCYYMMDD	005 011 012 034 Go to CLRF Reason Codes
DX07	Prescription Product/Service ID Qualifier	1	A	R	Identifies if the Product/Service ID is a NDC code, HCPCS code or other value. N = NDC H = HCPCS O = Other	001 010 011 Go to CLRF Reason Codes

DX08	Prescription Product/Service ID	30	A/N	R	Code value used to identify the product delivered. Must be a valid NDC Code or HCPCS/CPT Code. If HCPCS or Other (DX07='H' or 'O') must be 5 contiguous characters and must not contain special characters or spaces within the 5 contiguous characters. If NDC (DX07 = 'N'), must be 11 positions with no dashes. For additional information on the importance of the NDC format of exactly 11 characters with no dashes, please visit Common Question 1100-18.	001 011 013 014 029 Go to CLRF Reason Codes
DX09	Prescription Product/Service ID Modifier1	2	A/N	O	Code value used to provide further information about the product/service being performed.	011 Go to CLRF Reason Codes
DX10	Prescription Product/Service ID Modifier2	2	A/N	O	Code value used to provide further information about the product/service being performed.	011 Go to CLRF Reason Codes
DX11	Prescription Product/Service ID Modifier3	2	A/N	O	Code value used to provide further information about the product/service being performed.	011 Go to CLRF Reason Codes
DX12	Prescription Product/Service ID Modifier4	2	A/N	O	Code value used to provide further information about the product/service being performed.	011 Go to CLRF Reason Codes
DX13	Prescription Product/Service ID Modifier5	2	A/N	O	Code value used to provide further information about the product/service being performed.	011 Go to CLRF Reason Codes
DX14	Prescription Product/Service ID Modifier6	2	A/N	O	Code value used to provide further information about the product/service being performed.	011 Go to CLRF Reason Codes
DX15	Prescription Product/Service ID Modifier7	2	A/N	O	Code value used to provide further information about the product/service being performed.	011 Go to CLRF Reason Codes
DX16	Prescription Product/Service ID Modifier8	2	A/N	O	Code value used to provide further information about the product/service being performed.	011 Go to CLRF Reason Codes

DX17	Prescription Product/Service ID Modifier9	2	A/N	O	Code value used to provide further information about the product/service being performed.	011 Go to CLRF Reason Codes
DX18	Prescription Product/Service ID Modifier10	2	A/N	O	Code value used to provide further information about the product/service being performed.	011 Go to CLRF Reason Codes
DX19	Unit of Measure	2	A/N	O	Code value specifies the type of Quantity Reported for prescription claims. EA = Each (Being one or individual) GM = Grams ML = Milliliters DA = Days UN = Units MJ = Minutes WK = Weeks MO = Months Q1 = Quarter(Time) YR = Year LB = Pounds F2 = International Unit 01 = Actual Pounds ME = Milligrams 99 = Other	011 Go to CLRF Reason Codes
DX20	Quantity Dispensed	9	N	O	Quantity of services/products delivered for prescription claims. If value provided it must be numeric. Cannot be negative. Decimal must not be submitted. 6v3 (Example: 9.999 = 9999) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field.	003 011 Go to CLRF Reason Codes
DX21	Prescriber Provider ID Qualifier	2	A/N	O	Code value that defines the type of Prescriber Provider ID reported in the Prescriber Provider ID field for prescription claims. XX = NPI 12 = DEA 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other	011 Go to CLRF Reason Codes

DX22	Prescriber ID	80	A/N	O	ID of the Prescriber for prescription claims.	011 Go to CLRF Reason Codes
DX23	Service Location Zip Code	5	N	R	US Zip Code of the location where service was rendered. If the Service Location Zip Code is not available, submit the Rendering provider or Billing provider zip code. If neither of those is available, but the Plan Sponsor is certain the item or service was provided in the U.S., contact the ERRP Center. Please visit Common Question 1100-14 for additional information. Only submit 5 bytes for this field.	003 011 029 Go to CLRF Reason Codes
DX24	Item Plan Paid Amount	9	N	R	The dollar amount paid by the Plan for this claim item. 7v2 (Example: $543.21 = 54321) Cannot be negative. For additional information, please visit Common Question 1100-1. Cannot be blank. Decimal must not be submitted. May be zero if Early Retiree paid and the Plan did not. Otherwise, if the Item Plan Paid Amount is not available, omit this claim line from the Claim List. For additional information, please visit Common Question 1100-7. *Amount must be the full amount the plan paid for this claim line (not net of rebates). In contrast, the Cost Paid By Plan amount entered into the Cost Summary Report in the SWS is net of rebates. When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. For additional information on reporting adjusted claims, please visit Common Question 1100-4.	003 011 999 Go to CLRF Reason Codes

ERRP Secure Website Cost Adjustment Layouts

Cost Adjustment records are not required unless Cost Adjustments apply for a given Member ID/Member Group ID.

There are two Cost Adjustment records, the CA Cost Adjustment Layout and the CB Cost Adjustment Layout. The CA Cost Adjustment Layout is used to report price concessions occurring on or after June 1, 2010. The CB Cost Adjustment Layout is used to report price concessions occurring before June 1, 2010.

Plan Sponsors with plans that have a start date prior to June 1, 2010 and have cost adjustment claim records for claims with an Incurred Date before June 1, 2010 must report those cost adjustment claims separately from cost adjustments on claims incurred on or after June 1, 2010 using the CB Cost Adjustment Record Layout.

The Cost Adjustment Layouts are not required unless cost adjustments apply for a given Member ID/Member Group ID. Plan Sponsors should continue to use the Cost Adjustment Layout with the "CA" field number prefix in order to report price concessions occurring on claims incurred on or after June 1, 2010. Remember: All applicable Claim List Layouts must be submitted in one Claim List.

For additional information about reporting Cost Adjustments and allocating price concessions, please visit http://www.errp.gov/download/ERRP_Allocating_Price_Concessions.pdf and Common Question 1100-6.

ERRP Secure Website Cost Adjustment Layout
(For price concessions occurring on or after June 1, 2010)

Field No.	Name	Max Size	Data Type	Required/ Situational/ Optional	Description/Value	Claim List Response File Reason Codes
Cost Adjustment Record						
FH01	Record Type	2	A/N	R	CA = Cost Adjustment record type for price concession occurring on or after June 1, 2010	002 026 Go to CLRF Reason Codes
FH02	Application ID	10	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.	008 Go to CLRF Reason Codes
FH03	Plan Year Start Date	8	N	R	Date the Plan Year begins, provided in CCYYMMDD format. This date is specific to the Application ID.	008 Go to CLRF Reason Codes

CA02	Member ID	30	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 004 009 011 019 Go to CLRF Reason Codes
CA03	Member Group ID	20	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 011 Go to CLRF Reason Codes
CA04	Member Date of Birth	8	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.	004 005 011 Go to CLRF Reason Codes
CA05	Member Gender	1	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.	003 004 010 011 Go to CLRF Reason Codes
CA06	Cost Adjustment Amount	9	N	R	The total amount of post point-of-sale concessions and rebates for a particular member (i.e., one Cost Adjustment record per MemberID/Member Group ID combination). This amount must not be included in the Cost Paid by Plan in the Summary Cost Report in the Secure Website. Summing the Cost Adjustment amount for all members should equal the Total Cost Adjustment on the Claim List Trailer record. 7v2 (Example: $543.21 = 54321) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. Cannot be negative. Cannot be blank. Decimal must not be submitted.	003 006 011 020 Go to CLRF Reason Codes

ERRP Secure Website Cost Adjustment Layout
(For price concessions occurring before June 1, 2010)

This Cost Adjustment record is not required unless Cost Adjustments apply for a given Member ID/ Member Group ID.

Field No.	Name	Max Size	Data Type	Required/ Situational / Optional	Description/Value	Claim List Response File Reason Codes
Cost Adjustment Record						
FH01	Record Type	2	A/N	R	CB = Cost Adjustment record type for price concession occurring before June 1, 2010	002 026 Go to CLRF Reason Codes
FH02	Application ID	10	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.	008 Go to CLRF Reason Codes
FH03	Plan Year Start Date	8	N	R	Date the Plan Year begins, provided in CCYYMMDD format. This date is specific to the Application ID.	008 Go to CLRF Reason Codes
CB02	Member ID	30	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 004 009 011 019 Go to CLRF Reason Codes
CB03	Member Group ID	20	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 011 Go to CLRF Reason Codes
CB04	Member Date of Birth	8	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.	004 005 011 Go to CLRF Reason Codes

CB05	Member Gender	1	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.	003 004 010 011 Go to CLRF Reason Codes
CB06	Cost Adjustment Amount	9	N	R	The total amount of post point-of-sale concessions and rebates for a particular member (i.e., one Cost Adjustment record per MemberID/Member Group ID combination). This amount must not be included in the Cost Paid by Plan in the Summary Cost Report in the Secure Website. Summing the Cost Adjustment amount for all members should equal the Total Cost Adjustment on the Claim List Trailer record. 7v2 (Example: $543.21 = 54321 When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. Cannot be negative. Cannot be blank. Decimal must not be submitted.	003 006 011 020 Go to CLRF Reason Codes

ERRP Secure Website File Trailer Layout

Field No.	Name	Max Size	Data Type	Required/ Situational/ Optional	Description/Value	Claim List Response File Reason Codes
File Trailer Record						
FT01	Record Type	2	A	R	FT = File Trailer	022 Go to CLRF Reason Codes
FT02	Application ID	10	N	R	10-digit identifier assigned to the Plan Sponsor's ERRP application.	Go to CLRF Reason Codes
FT03	Plan Year Start Date	8	N	R	The starting date of the Plan Sponsor's plan year. CCYYMMDD	Go to CLRF Reason Codes
FT06	Total Number of Unique Retirees	6	N	R	Count of the unique Early Retirees within the Claim List. Example: If there is one unique person (i.e. one UPI) with two Member ID/ Group ID combinations, the unique retiree count should be one.	003 011 017 018 Go to CLRF Reason Codes
FT07	Total Number of Claims	9	N	R	Count of unique claim records within the Claim List. A unique claim is defined as a unique MemberID, Member GroupID, and ClaimID combination.	003 011 017 018 Go to CLRF Reason Codes
FT08	Total Number of Claim Service Line Records	11	N	R	Count of unique claim service line records within the Claim List.	003 011 017 018 Go to CLRF Reason Codes

FT09	Total Cost paid by Plan	11	N	R	Sum of Item Plan Paid Amount fields. Aggregated actual costs for health benefits paid by the plan for claims included in the Claim List. Subtracting the Total Cost Adjustment amount in this Trailer record from this Total Cost Paid by Plan amount must equal the amount to be entered in the Cost Paid By Plan field in the Summary Cost Report in the Secure Website. 9v2 (Example: $55.55=5555) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. Cannot be negative. Cannot be blank. Decimal must not be submitted.	003 011 017 Go to CLRF Reason Codes
FT10	Total Cost Paid by Early Retiree	11	N	R	Sum of Cost Paid by Early Retiree. Aggregated actual costs for health benefits paid by approved Early Retirees for claims included in the Claim List. This amount must equal the amount entered in the Cost Paid by Early Retiree in the Summary Cost Report in the Secure Website. Fill with zeros if the Plan Sponsor is not requesting reimbursement for Early Retiree Paid Costs. 9v2 (Example: $55.55=5555) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. Cannot be negative. Cannot be blank. Decimal must not be submitted.	003 011 017 Go to CLRF Reason Codes

FT11	Total Cost Adjustment	11	N	R	The aggregated total of all Cost Adjustment Amount fields (in the Cost Adjustment records) included in the Claim List. Fill with zeros if there is no amount. 9v2 (Example: $55.55=5555) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. Cannot be negative. Cannot be blank. Decimal must not be submitted.	003 011 017 Go to CLRF Reason Codes

ERRP Mainframe Claim List Layouts

Data Type Requirement:

If 'A', must be alphabetic character(s). Must be left justified with trailing spaces. If 'N', must be numeric character(s). Must be right justified with leading zeros. If 'A/N', must be alphabetic, numeric, or special characters (unless otherwise noted), or a combination of alphabetic and numeric character(s). Must be left justified with trailing spaces.

Required = Field shall be completed with valid values.
Situational = Field shall be completed with valid values in certain situations as described in the "Description/Value" column.
Optional = Field is not required and may be left blank if not available / not applicable.

For detailed information on the Claim List Response File Reason Codes associated with each Claim List field, refer to the "Claim List Response File Reason Codes" column of the Claim List Layout tables. Select a Reason Code link to jump directly to the applicable Reason Code description row in the Claim List Response File Reason Codes table. After reading the "What It Means" and "What You Should Do" information for the Reason Code, return to the applicable Claim List Layout table by selecting a Claim List Layout field number link from the "Claim List Layout Navigation" column.

ERRP Mainframe File Header Layout (*left justified, space filled)

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Required / Situational / Optional	Description/ Value	Claim List Response File Reason Codes
File Header								
FH01	Record Type	2	1	2	A	R	FH = File Header	002 998 Go to CLRF Reason Codes
FH02	Application ID	10	3	12	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.	Go to CLRF Reason Codes
FH03	Plan Year Start Date	8	13	20	N	R	Date the Plan Year begins, provided in CCYYMMDD format. This date is specific to the Application ID.	Go to CLRF Reason Codes
FH04	Create Date	8	21	28	N	R	The date the file is created in CCYYMMDD format.	005 Go to CLRF Reason Codes
FH05	Create Time	6	29	34	N	R	The time of day the file is created. HHMMSS	003 Go to CLRF Reason Codes
	Filler	266	35	300	A/N	R	Must be spaces	

ERRP Mainframe Professional Claim Layout

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Required / Situational / Optional	Description/ Value	Claim List Response File Reason Codes
Claim Header								
HP01	Record Type	2	1	2	A	R	HP = Professional	030 Go to CLRF Reason Codes
HP02	Member ID	30	3	32	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 004 009 Go to CLRF Reason Codes
HP03	Member Group ID	20	33	52	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 Go to CLRF Reason Codes
HP04	Claim Number	38	53	90	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the Plan Sponsor. For additional information about unique ID, visit Common Question 1100-3.	001 024 033 Go to CLRF Reason Codes
HP05	Derived Claim Indicator	1	91	91	A	R	Code value indicating whether or not a given claim was paid as a fee for service claim (Actual Claim) or paid under a capitated arrangement (Derived Claim). Set to "Y" if at least one service detail line is derived. Y = Derived Claim N = Actual Claim For additional information about derived claims, visit Common Question 1100-5.	001 010 Go to CLRF Reason Codes

HP06	Plan Paid Date	8	92	99	N	R	Date claim system adjudicated or processed the claim for payment. If there are multiple detail lines for the claim, and the date for one or more detail lines differs, populate the field with the most recent plan paid date. CCYYMMDD	005 Go to CLRF Reason Codes
HP07	Member Date of Birth	8	100	107	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.	004 005 Go to CLRF Reason Codes
HP08	Member Gender	1	108	108	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.	003 004 010 Go to CLRF Reason Codes
HP09	Cost Paid By Early Retiree	9	109	117	N	O	The aggregated actual costs for health benefits paid by approved Early Retirees for a given claim. Cannot be negative. Decimal must not be submitted. 7v2 (Example: $543.21 = 000054321) *Amount must be the full amount the member paid for the claim (not net of rebates).	003 Go to CLRF Reason Codes
	Filler	183	118	300	A/N	R	Must be spaces	
Service Item Detail								
DP01	Record Type	2	1	2	A	R	DP = Professional	031 Go to CLRF Reason Codes
DP02	Member ID	30	3	32	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree file List for a given individual.	001 032 Go to CLRF Reason Codes

DP03	Member Group ID	20	33	52	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree file List for a given individual.	001 032 Go to CLRF Reason Codes
DP04	Claim Number	38	53	90	A/N	R	Unique ID of a given claim that is assigned by the Plan Sponsor's claim processing system or as defined by the PS. For additional information about unique ID, visit Common Question 1100-3.	001 032 Go to CLRF Reason Codes
DP05	Claim Line Item Number	3	91	93	N	R	Line Number identifying the Service line associated with a claim. A claim must contain at least one service line. For additional information about Assigning Claim Line Item Number, visit Common Question 1100-2.	003 Go to CLRF Reason Codes
DP06	From Date of Service	8	94	101	N	R	Service Begin Date, Incurred date of claim CCYYMMDD	005 012 034 Go to CLRF Reason Codes
DP07	To Date of Service	8	102	109	N	R	Service Ending Date CCYYMMDD	005 Go to CLRF Reason Codes
DP08	Place of Service	2	110	111	A/N	O	Code value used to identify the location/facility where the service was rendered. Two-digit codes for health care professional claims to indicate the setting in which a service was provided.	Go to CLRF Reason Codes

DP09	Procedure Code	30	112	141	A/N	R	Code value used to designate the specific health interventions taken by medical professionals. Must be a valid HCPCS/CPT/NDC code. Cannot be less than 5 contiguous characters and must not contain special characters or spaces within the 5 contiguous characters. "XXXXX" is a valid alpha value for the Procedure Code (DP09) field when reporting bundled Professional claim detail lines. The bundled claim detail line must be followed by at least one subsequent claim detail line for which all the following conditions are true: valid value (not "XXXXX") entered in the Procedure Code (DP09) field and value entered in the Item Plan Paid Amount (DP24) field equal to zero. For information on how to report bundled claims, visit Common Question 1100-23.	001 007 013 014 029 Go to CLRF Reason Codes
DP10	Procedure Code Modifier1	2	142	143	A/N	O	Code value used to provide further information about the service being performed.	Go to CLRF Reason Codes
DP11	Procedure Code Modifier2	2	144	145	A/N	O	Code value used to provide further information about the service being performed.	Go to CLRF Reason Codes
DP12	Procedure Code Modifier3	2	146	147	A/N	O	Code value used to provide further information about the service being performed.	Go to CLRF Reason Codes
DP13	Procedure Code Modifier4	2	148	149	A/N	O	Code value used to provide further information about the service being performed.	Go to CLRF Reason Codes
DP14	ICD Code Qualifier	1	150	150	N	R	Code value used to identify which version of ICD is being utilized 1 = ICD-9 code 2 = ICD-10 code	003 010 Go to CLRF Reason Codes

DP15	Principal Diagnosis Code	7	151	157	A/N	R	Primary diagnosis code associated with the Member's condition. Must be a valid ICD code. If the Principal Diagnosis Code field is not available, do not submit this claim. Visit Common Question 1100-11 for additional information. Other than trailing spaces and/or one decimal, special characters are not allowed. The presence of the decimal is optional for ICD9; however the decimal is not allowed for ICD10. ICD9 code length must be at least 3 contiguous characters and no greater than 5 contiguous characters (when submitted without a decimal) or at least 4 contiguous characters and no greater than 6 contiguous characters (when submitted with a decimal). ICD10 code length must be at least 3 contiguous characters and no greater than 7 contiguous characters.	001 013 014 029 Go to CLRF Reason Codes
DP16	Other Diagnosis Code2	7	158	164	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DP15. Not allowed if primary is blank.	013 014 029 Go to CLRF Reason Codes
DP17	Other Diagnosis Code3	7	165	171	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DP15. Not allowed if primary is blank.	013 014 029 Go to CLRF Reason Codes
DP18	Other Diagnosis Code4	7	172	178	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DP15. Not allowed if primary is blank.	013 014 029 Go to CLRF Reason Codes

DP19	Quantity Qualifier	2	179	180	A/N	O	Code value used to identify the type of measurement used in the Unit Quantity field. DA = Days DH = Miles UN = Units MJ = Minutes WK = Weeks MO = Months Q1 = Quarter(Time) YR = Year LB = Pounds GM = Gram F2 = International Unit 01 = Actual Pounds ME = Milligram ML = Milliliter EA = Each 99 = Other	Go to CLRF Reason Codes
DP20	Unit Quantity	9	181	189	N	O	Quantity of services/product delivered. If a value is provided, it must be numeric. Decimal must not be submitted. 6v3 (Example: 999999.999 = 999999999)	003 Go to CLRF Reason Codes
DP21	Rendering Provider ID Qualifier	2	190	191	A/N	R	Code value used to identify the type of Provider ID reported in the Rendering Provider ID field. XX = NPI 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other Visit Common Question 1100-13 for additional information.	001 010 Go to CLRF Reason Codes
DP22	Rendering Provider ID	80	192	271	A/N	R	ID of the Provider/Supplier rendering the services to the Member. If the Rendering Provider/Supplier ID is not available, Plan Sponsors may submit the Billing Provider ID number instead. Please visit Common Question 1100-12 for additional information.	001 021 027 028 Go to CLRF Reason Codes

DP23	Service Location Zip Code	5	272	276	N	R	US Zip Code of the location where service was rendered. If the Service Location Zip Code is not available, submit the Rendering provider or Billing provider zip code. If neither of those is available, but the Plan Sponsor is certain the item or service was provided in the U.S., contact the ERRP Center. Please visit Common Question 1100-14 for additional information. Only provide 5 bytes for this field.	003 029 Go to CLRF Reason Codes
DP24	Item Plan Paid Amount	9	277	285	N	R	The dollar amount paid by the Plan for this claim item. Cannot be negative. For additional information, visit Common Question 1100-1. Cannot be blank. Decimal must not be submitted. May be zero if service line supports bundled service or claim. May be zero if Early Retiree paid and the Plan did not. Otherwise, if the Item Plan Paid Amount is not available omit this claim line from the Claim List. For additional information, visit Common Question 1100-7. 7v2 (Example: $543.21 = 000054321) *Amount must be the full amount the plan paid for the claim line (not net of rebates). In contrast, the Cost Paid By Plan amount entered in the Cost Summary Report in the SWS is net of rebates. For additional information on reporting adjusted claims, visit Common Question 1100-4.	003 999 Go to CLRF Reason Codes
	Filler	15	286	300	A/N	R	Must be spaces	

ERRP Mainframe Institutional Layout

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Required / Situational / Optional	Description/ Value	Claim List Response File Reason Codes
Claim Header								
HI01	Record Type	2	1	2	A	R	HI = Institutional	030 Go to CLRF Reason Codes
HI02	Member ID	30	3	32	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 004 009 Go to CLRF Reason Codes
HI03	Member Group ID	20	33	52	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 Go to CLRF Reason Codes
HI04	Claim Number	38	53	90	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the Plan Sponsor. For additional information about unique ID, visit Common Question 1100-3.	001 024 033 Go to CLRF Reason Codes
HI05	Derived Claim Indicator	1	91	91	A	R	Code value indicating whether or not a given claim was paid as a fee for service claim (Actual Claim) or paid under a capitated arrangement (Derived Claim). Set to "Y" if at least one detail line is derived. Y = Derived Claim N = Actual Claim For additional information about derived claims, visit Common Question 1100-5.	001 010 Go to CLRF Reason Codes
HI06	Plan Paid Date	8	92	99	N	R	Date claim system adjudicated or processed the claim for payment. If there are multiple detail lines for the claim, and the date for one or more detail lines differs, populate the field with the most recent plan paid date. CCYYMMDD	005 Go to CLRF Reason Codes

HI07	Member Date of Birth	8	100	107	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.	004 005 Go to CLRF Reason Codes
HI08	Member Gender	1	108	108	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.	003 004 010 Go to CLRF Reason Codes
HI09	Cost Paid By Early Retiree	9	109	117	N	O	The aggregated actual costs for health benefits paid by approved Early Retirees for a given claim. Cannot be negative. Decimal must not be submitted. 7v2 (Example: $543.21 = 000054321) *Amount must be the full amount the member paid for this claim (not net of rebates).	003 Go to CLRF Reason Codes
HI10	Type of Bill	3	118	120	A/N	R	NUBC Code value which identifies the specific type of bill for institutional claims. Typically for industry standard, Type of Bill is a four byte field, with the first byte being a leading zero. For ERRP purposes it is a three byte field; drop the leading zero (first byte). For ERRP, the first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence. If the Type of Bill information is available for your Institutional claims, report the correct Type of Bill code. Visit Common Question 1100-9 for additional information.	001 010 Go to CLRF Reason Codes
HI11	Facility Provider ID Qualifier	2	121	122	A/N	R	Code value that defines the type of Provider ID reported in the Facility Provider ID field. XX = NPI 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other If the Provider ID Qualifier field is not available, visit Common Question 1100-13 for additional information.	001 010 Go to CLRF Reason Codes

HI12	Facility Provider ID	80	123	202	A/N	R	ID of the Facility where item/service was provided. If the Facility Provider ID field is not available, Plan Sponsor may submit the Billing Provider ID number of the provider or supplier that furnished the item or service. Please visit Common Question 1100-12 for additional information.	001 021 027 028 Go to CLRF Reason Codes
	Filler	98	203	300	A/N	R	Must be spaces	
Service Item Detail								
DI01	Record Type	2	1	2	A	R	DI = Institutional	031 Go to CLRF Reason Codes
DI02	Member ID	30	3	32	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members) This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 032 Go to CLRF Reason Codes
DI03	Member Group ID	20	33	52	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 032 Go to CLRF Reason Codes
DI04	Claim Number	38	53	90	A/N	R	Unique ID of a given claim that is assigned by the Plan Sponsor's claim processing system or as defined by the PS. For additional information about unique ID, visit Common Question 1100-3.	001 032 Go to CLRF Reason Codes
DI05	Claim Line Item Number	3	91	93	N	R	Line Number identifying the Service line associated with a claim. A claim must contain at least one service line. For additional information about Assigning Claim Line Item Number, visit Common Question 1100-2.	003 Go to CLRF Reason Codes
DI06	Admission Date	8	94	101	N	R	Date admitted to facility for institutional claims. For non-acute care claims, if no Admission Date is available populate this field with the From Date of Service (DI07). CCYYMMDD Admission Date (DI06) is used as Incurred Date when Type of Bill (HI10) is "999" or starts with "11". Incurred date must fall within ERRP Eligibility dates for the plan year.	005 012 034 Go to CLRF Reason Codes

DI07	From Date of Service	8	102	109	N	R	Service Begin Date CCYYMMDD From Date of Service (DI07) is used as Incurred Date when Type of Bill (HI10) begins with a valid value other than “11”or “999” - valid value includes "000". Incurred date must fall within ERRP Eligibility dates for the plan year.	005 012 034 Go to CLRF Reason Codes
DI08	To Date of Service	8	110	117	N	R	Service Ending Date CCYYMMDD	005 Go to CLRF Reason Codes
DI09	ICD Code Qualifier	1	118	118	N	R	Code value used to identify which version of ICD is being utilized. 1 = ICD-9 code 2 = ICD-10 code	003 010 Go to CLRF Reason Codes
DI10	Principal Diagnosis Code	7	119	125	A/N	R	Primary diagnosis code associated with the Member’s condition. Must be a valid ICD code. If the Principal Diagnosis Code field is not available, visit Common Question 1100-11 for additional information. Other than trailing spaces and/or one decimal, special characters are not allowed. The presence of the decimal is optional for ICD9; however, the decimal is not allowed for ICD10. ICD9 code length must be at least 3 contiguous characters and no greater than 5 contiguous characters (without a decimal) or at least 4 contiguous characters and no greater than 6 contiguous characters (with a decimal). ICD10 code length must be at least 3 contiguous characters and no greater than 7 contiguous characters (without a decimal).	001 013 014 029 Go to CLRF Reason Codes
DI11	Other Diagnosis Code	7	126	132	A/N	O	Other diagnosis code associated with the Member’s condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.	013 014 029 Go to CLRF Reason Codes
DI12	Other Diagnosis Code2	7	133	139	A/N	O	Other diagnosis code associated with the Member’s condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.	013 014 029 Go to CLRF Reason Codes

DI13	Other Diagnosis Code3	7	140	146	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.	013 014 029 Go to CLRF Reason Codes
DI14	Other Diagnosis Code4	7	147	153	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.	013 014 029 Go to CLRF Reason Codes
DI15	Other Diagnosis Code5	7	154	160	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.	013 014 029 Go to CLRF Reason Codes

DI16	Principal ICD Procedure Code	7	161	167	A/N	S	Principal procedure performed within an institutional setting. Required only when procedure is performed. A valid ICD Principal Procedure Code, Revenue Code, or Procedure Code is required on each service item detail line. One, two, or all three fields may be populated. For additional information, visit Common Question 1100-10. Other than trailing spaces and/or one decimal, special characters are not allowed. The presence of the decimal is optional for ICD9; however, the decimal is not allowed for ICD10. ICD9 code must be at least 3 contiguous characters and no greater than 4 contiguous characters (without decimals) or at least 4 contiguous characters and no greater than 5 contiguous characters (with decimals). ICD10 code must be 7 contiguous characters in length without a decimal. For information on how to report bundled claims, visit Common Question 1100-23.	013 014 029 Go to CLRF Reason Codes

DI17	Other ICD Procedure Code	7	168	174	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.	013 014 015 029 Go to CLRF Reason Codes
DI18	Other ICD Procedure Code2	7	175	181	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.	013 014 015 029 Go to CLRF Reason Codes
DI19	Other ICD Procedure Code3	7	182	188	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.	013 014 015 029 Go to CLRF Reason Codes
DI20	Other ICD Procedure Code4	7	189	195	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.	013 014 015 029 Go to CLRF Reason Codes
DI21	Other ICD Procedure Code5	7	196	202	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.	013 014 015 029 Go to CLRF Reason Codes

DI22	Revenue Code	4	203	206	A/N	S	NUBC Code value that identifies the specific cost center related to the service for institutional claims. Individual services that contain Revenue Codes should be reported as documented in the claim. Revenue Code "0001" is an invalid code for ERRP purposes and a Claim List with this code will be rejected. A 4 byte code is strongly encouraged. However, if necessary, you may drop a leading zero (first character) and submit a 3 byte code. A code containing fewer than 3 bytes will cause an error. A valid ICD Principal Procedure Code, Revenue Code, or Procedure Code is required on each service item detail line. One, two, or all three fields may be populated. "XXXX" is the only valid alpha value for the Revenue Code (DI22) field. "XXXX" is a valid value when reporting bundled Institutional claim detail lines. The bundled claim detail line must be followed by at least one subsequent claim detail line for which all the following conditions are true: valid value entered in the Principal ICD Procedure Code (DI16) field; or valid value (not "XXXX") entered in the Revenue Code (DI22) field; or valid value entered in the Procedure Code (DI23) field; and value entered in the Item Plan Paid Amount (DI31) field equal to zero. For information on how to report bundled claims, please visit Common Question 1100-23.	007 010 013 016 029 Go to CLRF Reason Codes
DI23	Procedure Code	30	207	236	A/N	S	Code value used to designate the specific health interventions taken by medical professionals. Must be a valid HCPCS/HIPPS/CPT/ NDC code. Cannot be less than 5 contiguous characters and must not contain special characters or spaces within the 5 contiguous characters. A valid ICD Principal Procedure Code, Revenue Code, or Procedure Code is required on each service item detail line. One, two, or all three fields may be populated. For information on how to report bundled claims, visit Common Question 1100-23.	013 014 029 Go to CLRF Reason Codes
DI24	Procedure Code Modifier1	2	237	238	A/N	O	Code value used to provide further information about the service being performed.	Go to CLRF Reason Codes

DI25	Procedure Code Modifer2	2	239	240	A/N	O	Code value used to provide further information about the service being performed.	Go to CLRF Reason Codes
DI26	Procedure Code Modifier3	2	241	242	A/N	O	Code value used to provide further information about the service being performed.	Go to CLRF Reason Codes
DI27	Procedure Code Modifier4	2	243	244	A/N	O	Code value used to provide further information about the service being performed.	Go to CLRF Reason Codes
DI28	Quantity Qualifier	2	245	246	A/N	O	Code value used to identify the type of measurement used in the Unit Quantity field. DA = Days DH = Miles UN = Units MJ = Minutes WK = Weeks MO = Months Q1 = Quarter(Time) YR = Year LB = Pounds GM = Grams F2 = International Unit 01 = Actual Pounds ME = Milligram ML = Milliliter EA = Each 99= Other	Go to CLRF Reason Codes
DI29	Unit Quantity	9	247	255	N	O	Quantity of services/product delivered. If a value is provided, it must be numeric. Decimal must not be submitted. 6v3 (Example: 999,999.999 = 999999999)	003 Go to CLRF Reason Codes
DI30	Service Location Zip Code	5	256	260	N	R	US Zip Code of the location where service was rendered. If the Service Location Zip Code is not available, submit the Rendering provider or Billing provider zip code. If neither of those is available, but the Plan Sponsor is certain the item or service was provided in the U.S., contact the ERRP Center. Please visit Common Question 1100-14 for additional information. Only submit 5 bytes for this field.	003 029 Go to CLRF Reason Codes

DI31	Item Plan Paid Amount	9	261	269	N	R	The dollar amount paid by the Plan for this claim item. 7v2 (Example: $543.21 =000054321) Cannot be negative. For additional information, visit Common Question 1100-1. Cannot be blank. Decimal must not be submitted. May be zero if service line supports bundled service or claim. May be zero if Early Retiree paid and the Plan did not. Otherwise, if the Item Plan Paid Amount is not available omit this claim line from the Claim List. For additional information, visit Common Question 1100-7. *Amount must be the full amount the plan paid for the claim line (not net of rebates). In contrast, the Cost Paid By Plan amount entered into the Cost Summary Report in the SWS is net of rebates. For information on reporting adjusted claims, visit Common Question 1100-4.	003 999 Go to CLRF Reason Codes
	Filler	31	270	300	A/N	R	Must be spaces	

ERRP Mainframe Prescription Layout

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Required / Situational / Optional	Description/ Value	Claim List Response File Reason Codes
Claim Header								
HX01	Record Type	2	1	2	A	R	HX = Prescription	030 Go to CLRF Reason Codes
HX02	Member ID	30	3	32	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members) This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 004 009 Go to CLRF Reason Codes
HX03	Member Group ID	20	33	52	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 Go to CLRF Reason Codes
HX04	Claim Number	38	53	90	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the Plan Sponsor. For additional information about unique ID, visit Common Question 1100-3.	001 024 033 Go to CLRF Reason Codes
HX05	Derived Claim Indicator	1	91	91	A	R	Code value indicating whether or not a given claim was paid as a fee for service claim (Actual Claim) or paid under a capitated arrangement (Derived Claim). Set to "Y" if at least one detail line is derived. Y = Derived Claim N = Actual Claim For additional information about derived and not derived claims, visit Common Question 1100-5.	001 010 Go to CLRF Reason Codes
HX06	Plan Paid Date	8	92	99	N	R	Date claim system adjudicated or processed the claim for payment. If there are multiple detail lines for the claim, and the date for one or more detail lines differs, populate the field with the most recent plan paid date. CCYYMMDD	005 Go to CLRF Reason Codes

HX07	Member Date of Birth	8	100	107	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.	004 005 Go to CLRF Reason Codes
HX08	Member Gender	1	108	108	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.	003 004 010 Go to CLRF Reason Codes
HX09	Cost Paid By Early Retiree	9	109	117	N	O	*The aggregated actual costs for health benefits paid by approved Early Retirees for a given claim. Cannot be negative. Decimal must not be submitted. 7v2 (Example: $543.21 = 000054321) *Amount must be the full amount the member paid for this claim (not net of rebates).	003 Go to CLRF Reason Codes
HX10	Prescription Service Provider ID Qualifier	2	118	119	A/N	R	Code value that defines the type of Service Provider ID reported in the Prescription Service Provider ID field. XX = NPI 07 = NABP 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other Please visit Common Question 1100-13 for additional information.	001 010 Go to CLRF Reason Codes
HX11	Prescription Service Provider ID	80	120	199	A/N	R	ID of the Pharmacy or Supplier for prescription claims. In most cases, will be the NABP number. If the Pharmacy or Supplier Provider ID is not available, Plan Sponsors may submit the Billing Provider ID number instead. Please visit Common Question 1100-12 for additional information.	001 021 027 028 Go to CLRF Reason Codes
	Filler	101	200	300	A/N	R	Must be spaces	
Service Item Detail								

DX01	Record Type	2	1	2	A	R	DX = Prescription	031 Go to CLRF Reason Codes
DX02	Member ID	30	3	32	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 032 Go to CLRF Reason Codes
DX03	Member Group ID	20	33	52	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 032 Go to CLRF Reason Codes
DX04	Claim Number	38	53	90	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the PS. For additional information about unique ID, visit Common Question 1100-3.	001 032 Go to CLRF Reason Codes
DX05	Claim Line Item Number	3	91	93	N	R	Line Number identifying the Service line within a claim. A claim must contain at least one service line. For additional information about Assigning Claim Line Item Number, visit Common Question 1100-2.	003 Go to CLRF Reason Codes
DX06	Filled Date	8	94	101	N	R	Date Prescription was filled for prescription claims. CCYYMMDD	005 012 034 Go to CLRF Reason Codes
DX07	Prescription Product/Service ID Qualifier	1	102	102	A	R	Identifies if the Product/Service ID is a NDC code, HCPCS code or other value. N = NDC H = HCPCS O = Other	001 010 Go to CLRF Reason Codes

DX08	Prescription Product/Service ID	30	103	132	A/N	R	Code value used to identify the product delivered. Must be a valid NDC or HCPCS/CPT Code. If HCPCS or Other (DX07='H' or 'O') must be 5 contiguous characters and must not contain special characters or spaces within the 5 contiguous characters. If NDC (DX07 = 'N'), must be 11 positions with no dashes. For additional information on the importance of the NDC format of exactly 11 characters with no dashes, visit Common Question 1100-18.	001 013 014 029 Go to CLRF Reason Codes
DX09	Prescription Product/Service ID Modifier1	2	133	134	A/N	O	Code value used to provide further information about the product/service being performed.	Go to CLRF Reason Codes
DX10	Prescription Product/Service ID Modifier2	2	135	136	A/N	O	Code value used to provide further information about the product/service being performed.	Go to CLRF Reason Codes
DX11	Prescription Product/Service ID Modifier3	2	137	138	A/N	O	Code value used to provide further information about the product/service being performed.	Go to CLRF Reason Codes
DX12	Prescription Product/Service ID Modifier4	2	139	140	A/N	O	Code value used to provide further information about the product/service being performed.	Go to CLRF Reason Codes
DX13	Prescription Product/Service ID Modifier5	2	141	142	A/N	O	Code value used to provide further information about the product/service being performed.	Go to CLRF Reason Codes
DX14	Prescription Product/Service ID Modifier6	2	143	144	A/N	O	Code value used to provide further information about the product/service being performed.	Go to CLRF Reason Codes
DX15	Prescription Product/Service ID Modifier7	2	145	146	A/N	O	Code value used to provide further information about the product/service being performed.	Go to CLRF Reason Codes
DX16	Prescription Product/Service ID Modifier8	2	147	148	A/N	O	Code value used to provide further information about the product/service being performed.	Go to CLRF Reason Codes
DX17	Prescription Product/Service ID Modifier9	2	149	150	A/N	O	Code value used to provide further information about the product/service being performed.	Go to CLRF Reason Codes
DX18	Prescription Product/Service ID Modifier10	2	151	152	A/N	O	Code value used to provide further information about the product/service being performed.	Go to CLRF Reason Codes

DX19	Unit of Measure	2	153	154	A/N	O	Code value specifies the type of Quantity Reported for prescription claims. EA = Each (Being one or individual) GM = Grams ML = Milliliters DA = Days UN = Units MJ = Minutes WK = Weeks MO = Months Q1 = Quarter(Time) YR = Year LB = Pounds F2 = International Unit 01 = Actual Pounds ME = Milligrams 99 = Other	Go to CLRF Reason Codes
DX20	Quantity Dispensed	9	155	163	N	O	Quantity of services/products delivered for prescription claims. If value provided it must be numeric. Cannot be negative. Decimal must not be submitted. 6v3 (Example: 999,999.999= 999999999)	003 Go to CLRF Reason Codes
DX21	Prescriber Provider ID Qualifier	2	164	165	A/N	O	Code value that defines the type of Prescriber Provider ID reported in the Prescriber Provider ID field for prescription claims. XX = NPI 12 = DEA 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other	Go to CLRF Reason Codes
DX22	Prescriber ID	80	166	245	A/N	O	ID of the Prescriber for prescription claims.	Go to CLRF Reason Codes

DX23	Service Location Zip Code	5	246	250	N	R	US Zip Code of the location where service was rendered. If the Service Location Zip Code is not available, submit the Rendering provider or Billing provider Zip Code. If neither of those is available, but the Plan Sponsor is certain the item or service was provided in the U.S., contact the ERRP Center. Please visit Common Question 1100-14 for additional information. Only submit 5 bytes for this field.	003 029 Go to CLRF Reason Codes
DX24	Item Plan Paid Amount	9	251	259	N	R	The dollar amount paid by the Plan for this claim item. 7v2 (Example: $543.21 = 000054321) Cannot be negative. For additional information, visit Common Question 1100-1. Cannot be blank. Decimal must not be submitted. May be zero if Early Retiree paid and the Plan did not. Otherwise, if the Item Plan Paid Amount is not available omit this claim line from the Claim List. For additional information, visit Common Question 1100-7. *Amount must be the full amount the plan paid for this claim line (not net of rebates). In contrast, the Cost Paid By Plan amount entered into the Cost Summary Report in the SWS is net of rebates. For additional information on reporting adjusted claims, visit Common Question 1100-4.	003 999 Go to CLRF Reason Codes
	Filler	41	260	300	A/N	R	Must be spaces	

ERRP Mainframe Cost Adjustment Layouts

Cost Adjustment records are not required unless Cost Adjustments apply for a given Member ID/Member Group ID.

There are two Cost Adjustment records, the CA Cost Adjustment Layout and the CB Cost Adjustment Layout. The CA Cost Adjustment Layout is used to report price concessions occurring on or after June 1, 2010. The CB Cost Adjustment Layout is used to report price concessions occurring before June 1, 2010.

Plan Sponsors with plans that have a start date prior to June 1, 2010 and have cost adjustment claim records for claims with an Incurred Date before June 1, 2010 must report those cost adjustment claims separately from cost adjustments on claims incurred on or after June 1, 2010 using the CB Cost Adjustment Record Layout.

The Cost Adjustment Layouts are not required unless cost adjustments apply for a given Member ID/Member Group ID. Plan Sponsors should continue to use the Cost Adjustment Layout with the "CA" field number prefix in order to report price concessions occurring on claims incurred on or after June 1, 2010. Remember: All applicable Claim List Layouts must be submitted in one Claim List.

For additional information about reporting Cost Adjustments and allocating price concessions, visit http://www.errp.gov/download/ERRP_Allocating_Price_Concessions.pdf and Common Question 1100-6.

ERRP Mainframe Cost Adjustment Layout
(For price concessions occurring on or after June 1, 2010)

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Required / Situational / Optional	Description/ Value	Claim List Response File Reason Codes
Cost Adjustment Record								
CA01	Record Type	2	1	2	A	R	CA = Cost Adjustment record type for price concession occurring on or after June 1, 2010.	Go to CLRF Reason Codes
CA02	Member ID	30	3	32	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members) This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 004 009 019 Go to CLRF Reason Codes
CA03	Member Group ID	20	33	52	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 Go to CLRF Reason Codes
	Filler	47	53	99	A/N	R	Fill with spaces	

CA04	Member Date of Birth	8	100	107	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.	004 005 Go to CLRF Reason Codes
CA05	Member Gender	1	108	108	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.	003 004 010 Go to CLRF Reason Codes
CA06	Cost Adjustment Amount	9	109	117	N	R	The total amount of post point-of-sale concessions and rebates for a particular member (i.e., one Cost Adjustment record per MemberID/Member Group ID combination). This amount must not be included in the Cost Paid by Plan in the Summary Cost Report in the Secure Website. Summing the Cost Adjustment amount for all members should equal the Total Cost Adjustment on the Claim List Trailer record. 7v2 (Example: $543.21 = 000054321) Cannot be negative. Cannot be blank. Decimal must not be submitted.	003 006 020 Go to CLRF Reason Codes
	Filler	183	118	300	A	R	Must be spaces	

ERRP Mainframe Cost Adjustment Layout
(For price concessions occurring before June 1, 2010)

This Cost Adjustment record is not required unless Cost Adjustments apply for a given Member ID/Member Group ID.

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Required / Situational / Optional	Description/ Value	Claim List Response File Reason Codes
Cost Adjustment Record								
CB01	Record Type	2	1	2	A	R	CB = Cost Adjustment record type for price concession occurring before June 1, 2010	Go to CLRF Reason Codes
CB02	Member ID	30	3	32	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members) This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 004 009 019 Go to CLRF Reason Codes
CB03	Member Group ID	20	33	52	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.	001 Go to CLRF Reason Codes
	Filler	47	53	99	A/N	R	Fill with spaces.	
CB04	Member Date of Birth	8	100	107	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.	004 005 Go to CLRF Reason Codes
CB05	Member Gender	1	108	108	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.	003 004 010 Go to CLRF Reason Codes

CB06	Cost Adjustment Amount	9	109	117	N	R	The total amount of post point-of-sale concessions and rebates for a particular member (i.e., one Cost Adjustment record per MemberID/Member Group ID combination). This amount must not be included in the Cost Paid by Plan in the Summary Cost Report in the Secure Website. Summing the Cost Adjustment amount for all members should equal the Total Cost Adjustment on the Claim List Trailer record. 7v2 (Example: $543.21 = 000054321) Cannot be negative. Cannot be blank. Decimal must not be submitted.	003 006 020 Go to CLRF Reason Codes
	Filler	183	118	300	A	R	Must be spaces	

ERRP Mainframe File Trailer Layout

Field No.	Name	Size	Start Pos.	End Pos.	Data Type	Required / Situational / Optional	Description/ Value	Claim List Response File Reason Codes
File Trailer								
FT01	Record Type	2	1	2	A	R	FT = File Trailer	Go to CLRF Reason Codes
FT02	Application ID	10	3	12	N	R	10-digit identifier assigned to the Plan Sponsor's ERRP application.	Go to CLRF Reason Codes
FT03	Plan Year Start Date	8	13	20	N	R	The starting date of the Plan Sponsor's plan year. CCYYMMDD	Go to CLRF Reason Codes
FT04	Create Date	8	21	28	N	R	The date the file is created. CCYYMMDD	005 Go to CLRF Reason Codes
FT05	Create Time	6	29	34	N	R	The time of day the file is created. HHMMSS	003 Go to CLRF Reason Codes
FT06	Total Number of Unique Retirees	6	35	40	N	R	Count of the unique Early Retirees within the Claim List. Example: If there is one unique person (i.e. one UPI) with two Member ID/ Group ID combinations, the unique retiree count should be one.	003 017 018 Go to CLRF Reason Codes

FT07	Total Number of Claims	9	41	49	N	R	Count of unique claim records within the Claim List. A unique claim is defined as a unique MemberID, Member GroupID, and ClaimID combination.	003 017 018 Go to CLRF Reason Codes
FT08	Total Number of Claim Service Line Records	11	50	60	N	R	Count of unique claim service line records within the Claim List.	003 017 018 Go to CLRF Reason Codes
FT09	Total Cost paid by Plan	11	61	71	N	R	Sum of Item Plan Paid Amount fields. Aggregated actual costs for health benefits paid by the plan for claims included in the Claim List. Subtracting the Total Cost Adjustment amount in this Trailer record from this Total Cost Paid by Plan amount must equal the amount to be entered in the Cost Paid By Plan field in the Summary Cost Report in the Secure Website. 9v2 (Example: $555,555,555.55=55555555555) Cannot be negative. Cannot be blank. Decimal must not be submitted.	003 017 Go to CLRF Reason Codes
FT10	Total Cost paid by Early Retiree	11	72	82	N	R	Sum of Cost Paid by Early Retiree. Aggregated actual costs for health benefits paid by approved Early Retirees for claims included in the Claim List. This amount must equal the amount entered in the Cost Paid by Early Retiree in the Summary Cost Report in the Secure Website. Fill with zeros if the Plan Sponsor is not requesting reimbursement for Early Retiree Paid Costs. 9v2 (Example: $555,555,555.55=55555555555) Cannot be negative. Cannot be blank. Decimal must not be submitted.	003 017 Go to CLRF Reason Codes

FT11	Total Cost Adjustment	11	83	93	N	R	The aggregated total of all Cost Adjustment Amount fields (in the Cost Adjustment records) included in the Claim List. Fill with zeros if there is no amount. 9v2 (Example: $555,555,555.55=55555555555) Cannot be negative. Cannot be blank. Decimal must not be submitted.	003 017 Go to CLRF Reason Codes
	Filler	207	94	300	A/N	R	Must be spaces	

ERRP Claim List Response File Reason Codes

This section describes Claim List Response File (CLRF) Reason Codes. Refer to the ERRP Claim List Automated Process Overview for a detailed description of the five levels of automated Claim List processing that generate CLRF Reason Codes. Refer to the ERRP Claim List Response File Reason Codes (Level II – Level V Edits) for detailed descriptions of CLRF Reason Codes and information on how to resolve errors identified on the CLRF during automated processing.

ERRP Claim List Automated Process Overview

A Claim List submitted to the ERRP Center goes through five levels (I – V) of automated processing. The first level of editing (Level I) is related to Claim List's file formatting and associated error reason codes do **not** get reported on the Claim List Response File (CLRF). The remaining file level edits (Levels II – V) are reported on the CLRF. Claim Lists processed by the ERRP Center go through one level of file editing at a time, in order, starting with Level I and ending with Level V.

- **Level I** (File Format / File Submission Level Edits) – if errors are found, no further processing occurs; a Claim List Response File is not generated. The PS will receive a phone call from the ERRP Center to discuss the errors that were generated. The Claim List is not considered error-free and the reimbursement process cannot continue until an error-free list is received. Once the Level I Edits are resolved and the full file replacement Claim List is resubmitted, it should continue processing through Level II. Following is a list of Level I Edits.
  - Record length does not match appropriate fixed-length Claim List file format.
  - Record format does not match appropriate fixed-length Claim List file format.
  - Missing File Header (Mainframe Only) or File Trailer.
  - Application ID in the Claim List File Header record (FH) and the File Trailer record (FT) do not match.
  - Application ID in the Claim List does not match to the ERRP database.
  - Plan Year Start Date in the Claim List File Header record (FH) and the File Trailer record (FT) do not match.
  - Plan Year Start Date in the Claim List does not match to the ERRP database for the specific Application ID.
  - Received a Mainframe Claim List from a Plan Sponsor or Vendor whose submission method is designated as ERRP SWS.
  - Received a SWS Claim List from a Plan Sponsor whose submission method is designated as Mainframe PS or Vendor.
  - Received a Mainframe Claim List from a different Vendor than is recorded in the ERRP database for a specific Application ID / Plan Year combination.
  - Received a Mainframe Claim List from a Vendor rather than a Plan Sponsor for a specific Application ID / Plan Year combination.

- **Level II (**File Level Edits) – if errors are found, no further processing occurs; a Claim List Response File is generated. The Claim List is not considered error-free and the reimbursement process cannot continue until an error-free list is received. Once the Level II edits are resolved and the Claim List is resubmitted, it will continue processing through Level III.

- **Level III (**Field Level Edits/Validate ERRP Eligibility Periods) – if claim errors are found, that claim and all other claims for that individual early retiree stop processing at the end of Level III; the early retiree's claims do not proceed to Level IV. The only claims that proceed to Level IV processing are claims for individual early retirees that did **NOT** error in Level III. A CLRF is not generated until the end of Level IV processing and includes both Level III and Level IV edits as applicable. The Claim List is not considered error-free and the reimbursement process cannot continue until an error-free Claim List is received. Once the Level III and/or IV edits are resolved and the Claim List is resubmitted, it will continue processing through Level IV and V as applicable.

  For Example: The plan sponsor submits a Claim List to ERRP Center including data for three unique early retirees: Jane Smith, Ella Frank, and Frank Ross. The Claim List passes Level I processing and proceeds to Level II. The Claim List passes Level II editing and proceeds to Level III. During Level III processing an error is generated by Jane Smith's claim data, but Ella Frank and Frank Ross are error-free. Processing stops for Jane Smith at Level III; Ella Frank and Frank Ross proceed to Level IV. During Level IV processing an error is generated by Ella Frank's claim data, but Frank Ross is error-free. Because there are errors generated during Level III and Level IV processing, processing for the Claim List does not proceed to Level V; a Claim List Response File is generated.

The resulting Claim List Response file includes Level III Reason Codes for Jane Smith, Level IV Reason Codes for Ella Frank, and no Reason Codes for Frank Ross.

- **Level IV** (Person Level Edits and Duplicate Processing) – if any claim errors in Level IV, the Claim List will not continue to Level V processing and a CLRF will be generated. The Claim List is not considered error-free and the reimbursement process cannot continue until an error-free list is received. Once the Level IV edits are resolved and the Claim List is resubmitted, it will continue processing through Level V.

- **Level V** (Trailer Validation) – if errors are found, a Claim List Response File will be generated. The Claim List is not considered error-free and the reimbursement process cannot continue until an error-free list is received. Once the Level V edits are resolved and the Claim List is resubmitted, it will continue processing and be set to an 'Accepted' status. Summary Cost Data reporting will be available in the ERRP SWS to continue the reimbursement process.

Note: All claims in a Claim List will complete processing through the respective level edits regardless of where in the file the error occurs. For example, if an error is encountered in Level II processing, all the claims will complete Level II processing and be addressed on the CLRF, as applicable.

ERRP Claim List Response File Reason Codes (Level II – Level V Edits)

Claim List Reason Codes are codes that correspond to a specific message about claim data on the Claim List submitted to the ERRP Center. If your Claim List Response File (CLRF) contains a reason code, it has one or more errors and was consequently rejected. A rejected Claim List is set to an 'Invalid' status on the ERRP SWS which means you cannot proceed with Cost Summary data reporting or a reimbursement request for that application until a new Claim List is submitted and accepted. ***Any CLRF with an error reason code requires the Plan Sponsor to resubmit a corrected Claim List.*** Please keep in mind that each Claim List is a full replacement of the previous file for that application plan year. Consequently, each claim line that has received an error code must be submitted correctly or omitted, if applicable, for the next full replacement Claim List submitted by the Plan Sponsor.

For assistance understanding and resolving the error reason codes on your Claim List, refer to the information below. Please carefully review the following detailed Reason Code information, specifically the 'What It Means' and 'What You Should Do' columns. A Claim List Response File line may display up to four Reason Codes as applicable. If more than four error reason codes are applicable, only the first four will be provided on the CLRF.

For detailed information on a Claim List Layout field, refer to the "Claim List Layouts Navigation" column of the "Claim List Response File Reason Codes" table. Select a Claim List field number link to jump directly to the applicable Claim List field description and/or the applicable File Header, Professional, Institutional, Prescription, Cost Adjustment (CA), Cost Adustment (CB), or File Trailer layout table.

Note: There are several fields that are included in all the Claim List Record Types (Professional, Institutional, Prescription, and Cost Adjustment); specifically, Record Type (FH01), Application ID (FH02), and Plan Year Start Data (FH03). In such cases, the hyper link for these fields listed in the Claim List Layout Navigation column will take you to the Professoinal Claim List Layout by default. Regardless of the type of claim these errors are found on, the Description/Value is the same in all record type layouts.

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
II	002	The Record Type is invalid	The Record Type entered in the Claim List does not match one of the specified values.	Enter a valid value in the Record Type field. Valid Mainframe Record Types: FH, HP, DP, HI, DI, HX, DX, CA, CB, FT Valid SWS Record Types: DP, DI, DX, CA, CB, FT The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** FH01 Return to SWS CL Layout **MF:** FH01 Return to MF CL Layout
II	008	Application ID or Plan Year Start Date within each claim detail line does not match the Application ID or Plan Year Start date on the Secure Website	**SWS Only** – Application ID or Plan Year Start Date on the submitted Claim List detail line does not match the Application ID or Plan Year Start date on the Secure Website.	Application ID in File Trailer must match Application ID in the claim detail line; Plan Year Start Date in File Trailer must match Plan Year Start Date in the claim detail line. Enter a valid Application ID in field FH02, or a valid Plan Year Start Date in field FH03. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** FH02, FH03 Return to SWS CL Layout
II	011	Value entered exceeds maximum length	**SWS Only** – Value entered exceeds the maximum length of the specified field.	Verify that the value entered in the field includes the correct number of characters and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** Professional, Institutional, Prescription, Cost Adjustment (CA), Cost Adjustment (CB), File Trailer
II	022	More than one File Trailer	**SWS Only** – The SWS Claim List contains more than one File Trailer.	Only one File Trailer can exist per SWS Claim List. Remove duplicate File Trailer(s) from the Claim List and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** FT01 Return to SWS CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
II	023	Inconsistent Claim Level Data	**SWS Only** – The data provided in the claim header section is different for the subsequent service line items within the same claim.	For the claim that is in error, verify that each detail service line contains the same claim level data elements: • Member DOB (HP07, HI07, HX07) • Member Gender (HP08, HI08, HX08) • Type of Bill – Institutional only (HI10) • Facility Provider ID Qualifier - Institutional only (HI11) • Facility Provider ID - Institutional only (HI12) • Prescription Service Provider ID Qualifier – Prescription only (HX10) • Prescription Service Provider ID – Prescription only (HX11) After verifying, edit the Claim List as applicable and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** HP07, HP08, HI07, HI08, HI10, HI11, HI12, HX07, HX08, HX10, HX11 Return to SWS CL Layout
II	025	Invalid Cost Paid by Early Retiree	**SWS Only** – The Cost Paid by Early Retiree field on any service line other than the first within the same claim contains a value other than 0.	Enter the Cost Paid by Early Retiree on the first service line item of your SWS .CSV Claim List only, enter 0 in all subsequent Cost Paid By Early Retiree fields (HP09, HI09, HX09), and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** HP09, HI09, HX09 Return to SWS CL Layout
II	026	Incorrect number of fields for this Record Type	**SWS Only** – The SWS Claim List detail line does not contain the correct number of fields.	Verify the number of fields by Record Type for the Claim List detail line and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** FH01 Return to SWS CL Layout
II	030	Claim Header has no associated Claim Detail lines	**Mainframe Only** – The Claim Header has no associated Claim Detail lines.	Verify the format and content of the Claim List and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**MF:** HP01, HI01, HX01 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
II	031	Service line item is inconsistent with Claim Header Record Type	**Mainframe Only** – The service line item Record Type is inconsistent with the parent Claim Header Record Type (HP:DI, HI:DP, HX:DI).	Verify that the service line item Record Type matches the parent Claim Header Record Type and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**MF:** DP01, DI01, DX01 Return to MF CL Layout
II	032	Service line item does not match Claim Header	**Mainframe Only** – The repeating data (Member ID, Member Group ID, and Claim Number) in the service line item is different from the Member ID, Member Group ID, or Claim Number value in the Claim Header.	Verify that the service line item Member ID, Member Group ID, or Claim Number value matches the Claim Header Member ID, Member Group ID, or Claim Number value and resubmit. Verify the format and content of the Claim List and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**MF:** DP02, DP03, DP04, DI02, DI03, DI04, DX02, DX03, DX04 Return to MF CL Layout
II	033	Number of service line items exceeds 999	The number of claim service line items within a single unique claim is greater than 999.	Verify the format and content of the Claim List, correct the number of service line items by separating your data into unique claims containing 999 or fewer service line items, and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** HP04, HI04, HX04 Return to SWS CL Layout **MF:** HP04, HI04, HX04 Return to MF CL Layout
II	998	No Claim Detail lines	**Mainframe Only** – The Claim List contains no Claim Detail lines.	Claim List must include at least one detail line. Verify the format and content of the Claim List and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**MF:** FH01 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
III	001	The required field is blank or null	The required Claim List field is blank or contains a null value.	Enter a valid alphanumeric value in the required field. The value must not be all spaces. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List prior to being permitted to submit Cost Summary Data and a Reimbursement Request.	**SWS:** HP02, HP03, HP04, HP05, DP09, DP15, DP21, DP22, HI02, HI03, HI04, HI05, HI10, HI11, HI12, DI10, HX02, HX03, HX04, HX05, HX10, HX11, DX07, DX08, CA02, CA03, CB02, CB03 Return to SWS CL Layout **MF:** HP02, HP03, HP04, HP05, DP02, DP03, DP04, DP09, DP15, DP21, DP22, HI02, HI03, HI04, HI05, HI10, HI11, HI12, DI02, DI03, DI04, DI10, HX02, HX03, HX04, HX05, HX10, HX11, DX02, DX03, DX04, DX07, DX08, CA02, CA03, CB02, CB03 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
III	003	The numeric field contains a non-numeric value	The numeric Claim List field contains a non-numeric value. Examples of numeric values are: 1234567890.	Enter a valid numeric value. The value **must** be all numbers (1234567890). The value **cannot** contain spaces, letters, or special characters including decimals. Optional fields may be null or blank. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** HP08, HP09, DP05, DP14, DP20, DP23, DP24, HI08, HI09, DI05, DI09, DI29, DI30, DI31, HX08, HX09, DX05, DX20, DX23, DX24, CA05, CA06, CB05, CB06, FT06, FT07, FT08, FT09, FT10, FT11 Return to SWS CL Layout **MF:** FH05, HP08, HP09, DP05, DP14, DP20, DP23, DP24, HI08, HI09, DI05, DI09, DI29, DI30, DI31, HX08, HX09, DX05, DX20, DX23, DX24, CA05, CA06, CB05, CB06, FT05, FT06, FT07, FT08, FT09, FT10, FT11 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
III	004	The Member ID/ Member Group ID/ Member Date Of Birth/ Member Gender combination cannot be found in the ERRP Database	The field does not contain a valid value that matches any records when compared to the Early Retiree List Response File for a specific application plan year. The Eligibility List includes: • Member ID • Member Group ID • DOB • Gender	This reason code displays on the Member ID (HP02, HI02, HX02, CA02, CB02) only, but may apply to both the Member ID and Member Group ID (HP03, HI03, HX03, CA03, CB03) fields for each record that caused the error. If the error occurs on these fields, verify the values in these fields, remove ineligible member's claims from the Claim List if applicable, and resubmit. If the error occurs on field HP07, HI07, HX07, CA04, or CB04, enter the correct Date of Birth (CCYYMMDD) for this member or remove ineligible member's claims from Claim List. If the error occurs on field HP08, HI08, HX08, CA05, or CB05, enter the correct Member's Gender (0 = gender unknown; 1 = male; 2 = female) or remove ineligible member's claims from the Claim List. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** HP02, HP07, HP08, HI02, HI07, HI08, HX02, HX07, HX08, CA02, CA04, CA05, CB02, CB04, CB05 Return to SWS CL Layout **MF:** HP02, HP07, HP08, HI02, HI07, HI08, HX02, HX07, HX08, CA02, CA04, CA05, CB02, CB04, CB05 Return to MF CL Layout
III	005	Invalid Date	The value entered in one of the following Date fields is not in the correct format, contains an unreasonable date (for example 18250215 where the year is 1825), or contains a future date: • Plan Year Start Date (FH03, FT03) • Create Date (FH04, FT04) • Plan Paid Date (HP06, HI06, HX06) • Member Date of Birth (HP07, HI07, HX07, CA04, CB04) • From Date of Service (DP06, DI07) • To Date of Service (DP07, DI08) • Admission Date (DI06) • Filled Date (DX06)	Enter a valid Date in CCYYMMDD format. The value **must** be all numbers (1234567890). The value **cannot** contain spaces, letters, or special characters. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** HP06, HP07, DP06, DP07, HI06, HI07, DI06, DI07, DI08, HX06, HX07, DX06, CA04, CB04 Return to SWS CL Layout **MF:** FH04, HP06, HP07, DP06, DP07, HI06, HI07, DI06, DI07, DI08, HX06, HX07, DX06, CA04, CB04, FT04 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
III	007	The Item Plan Paid amount must be zero on a subsequent claim line prior to the next bundled set	The claim includes a claim detail line containing 'XXXX' or 'XXXXX' indicating a bundled service, but that claim detail line is not followed by at least one claim detail line with an Item Plan Paid Amount of zero.	Verify that claim detail line containing 'XXXX' or 'XXXXX' is followed by at least one claim detail line that includes the details about the items and/or services that were paid by the plan in the bundled payment to include Principal ICD Procedure Code (DI16), Revenue Code (DI22), and/or Procedure Code (D123, and an Item Plan Paid Amount of zero. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DP09, DI22 Return to SWS CL Layout **MF:** DP09, DI22 Return to MF CL Layout
III	009	More than one Member ID/Member Group ID Combination Match found	The Member ID/Member Group ID Combination matches more than one ERRP-Eligible individual for a given application plan year.	This reason code displays on the Member ID (HP02, HI02 HX02, CA02, CB02) field. Verify the values in these fields, remove the ineligible member's claims from the Claim List or update and resubmit an ERL if applicable, and resubmit the Claim List. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** HP02, HI02, HX02, CA02, CB02 Return to SWS CL Layout **MF:** HP02, HI02, HX02, CA02, CB02 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
III	010	Invalid Value	The value entered in any of the following fields is not a valid value: • Derived Claim Indicator (HP05, HI05, HX05) • Member Gender (HP08, HI08, HX08, CA05, CB05) • ICD Code Qualifier (DP14, DI09) • Rendering Provider ID Qualifier (DP21) • Type Of Bill (HI10) • Revenue Code (DI22) • Facility Provider ID Qualifier (HI11) • Prescription Service Provider ID Qualifier (HX10) • Prescription Product/Service ID Qualifier (DX07)	Enter a valid value in the field(s) and resubmit: • Derived Claim Indicator (HP05, HI05, HX05) Y = Derived Claim; N = Actual Claim • Member Gender (HP08, HI08, HX08, CA05, CB05) 0 = Unknown; 1 = Male; 2 = Female • ICD Code Qualifier (DP14, DI09) 1 = ICD-9 code; 2 = ICD-10 code • Rendering Provider ID Qualifier (DP21) XX = NPI; 24 = EIN; 34 = SSN; G2 = Plan Provider ID; 99 = Other • Type Of Bill (HI10) For ERRP, this is a three byte field; drop the leading zero (first byte). • NUBC Revenue Code value (DI22) Bundled Services = XXXX and is acceptable; Total Charge = 0001 and is an invalid code for ERRP and is, rejected by ERRP • Facility Provider ID Qualifier (HI11) XX = NPI; 24 = EIN; 34 = SSN; G2 = Plan Provider ID; 99 = Other • Prescription Service Provider ID Qualifier (HX10) XX = NPI; 07 = NABP; 24 = EIN; 34 = SSN; G2 = Plan Provider ID; 99 = Other • Prescription Product/Service ID Qualifier (DX07) N = NDC; H = HCPCS; O = Other The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** HP05, HP08, DP14, DP21, HI05, HI08, HI10, HI11, DI09, DI22, HX05, HX08, HX10, DX07, CA05, CB05 Return to SWS CL Layout **MF:** HP05, HP08, DP14, DP21, HI05, HI08, HI10, HI11, DI09, DI22, HX05, HX08, HX10, DX07, CA05, CB05 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
III	012	Incurred Date not within ERRP Eligibility dates for this plan year	The value entered in the Date field does not fall within the Eligibility dates returned on the ERL Response file for a Member ID/Member Group ID combination: • Professional = From Date of Service (DP06) • Institutional = Admission Date (DI06) when Type of Bill (HI10) is "999" or starts with "11" • Institutional = From Date of Service (DI07) when the Type of Bill (HI10) begins with a valid value other than "11"or "999" - valid value includes "000" • Prescription = Filled Date (DX06)	Claims where the Incurred Date is not within the ERRP eligibility periods returned on the ERL response file for the individual must be removed from the Claim List. Verify the Claim List Incurred Date and Early Retiree List Eligibility dates, remove ineligible claim from the Claim List if applicable, and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DP06, DI06, DI07, DX06 Return to SWS CL Layout **MF:** DP06, DI06, DI07, DX06 Return to MF CL Layout
III	013	Excluded Code	The value entered in one of the following fields is on the excluded code lists: • Procedure Code (DP09, DI23) • Principal ICD Procedure Code (DI16) • Prescription Product Service ID (DX08) • Other ICD Procedure Code (DI17, DI18, DI19, DI20, DI21) • Diagnosis Code (DP15, DP16, DP17, DP18 – Professional; DI10, DI11, DI12, DI13, DI14, DI15 - Institutional)	Claim lines that include excluded codes must be removed from the Claim List as well as any associated Cost Paid by Early Retiree and Cost Adjustment Amounts. Verify the value, remove ineligible claim from the Claim List if applicable, and resubmit. For more information, refer to the: • ERRP Medicare Excluded CPT-HCPCS Codes List • ERRP Medicare Excluded ICD-9 Codes List The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DP09, DP15, DP16, DP17, DP18, DI10, DI11, DI12, DI13, DI14, DI15, DI16, DI17, DI18, DI19, DI20, DI21, DI22, DI23, DX08 Return to SWS CL Layout **MF:** DP09, DP15, DP16, DP17, DP18, DI10, DI11, DI12, DI13, DI14, DI15, DI16, DI17, DI18, DI19, DI20, DI21, DI22, DI23, DX08 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
III	014	Invalid Format or Length	The value entered for one of the following codes is an incorrect format or incorrect length: • ICD9 Procedure Code or ICD9 Diagnosis Code • ICD10 Procedure Code or ICD10 Diagnosis Code • HCPCS code • NDC code	Verify the value entered in the data field and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DP09, DP15, DP16, DP17, DP18, DI10, DI11, DI12, DI13, DI14, DI15, DI16, DI17, DI18, DI19, DI20, DI21, DI23, DX08 Return to SWS CL Layout **MF:** DP09, DP15, DP16, DP17, DP18, DI10, DI11, DI12, DI13, DI14, DI15, DI16, DI17, DI18, DI19, DI20, DI21, DI23, DX08 Return to MF CL Layout
III	015	Other ICD Procedure Code is valued when Principal ICD Procedure Code not valued	The Other ICD Procedure Code field (Institutional = DI17, DI18, DI19, DI20, DI21) is valued when Principal ICD Procedure Code field (DI16) is not valued.	Enter a valid value in the Principal ICD Procedure Code field (DI16) and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DI17, DI18, DI19, DI20, DI21 Return to SWS CL Layout **MF:** DI17, DI18, DI19, DI20, DI21 Return to MF CL Layout
III	016	Required field missing; service requires a Principal ICD Procedure Code, Revenue Code, or Procedure Code	This Error Reason Code displays on Revenue Code field (DI22). For an Institutional claim, one of the following fields must contain data for each service line submitted: • Principal ICD Procedure Code • Revenue Code • Procedure Code	Enter a valid value in the Principal ICD Procedure Code, Revenue Code, or Procedure Code as applicable and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DI22 Return to SWS CL Layout **MF:** DI22 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
III	018	Fields in File Trailer cannot be zero	The Total Number of Unique Retirees field (FT06), Total Number Of Unique Claims field (FT07), or Total Number Of Claim Service Line Records field (FT08) in the File Trailer contains a value of zero.	Verify that a value greater than zero is entered in the Total Number of Unique Retirees field (FT06), Total Number Of Unique Claims field (FT07), or Total Number Of Claim Service Line Records field (FT08) and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** FT06, FT07, FT08 Return to SWS CL Layout **MF:** FT06, FT07, FT08 Return to MF CL Layout
III	021	Invalid NPI format	The value entered in the Provider ID field is not ten characters long when the Provider ID Qualifier is populated with “XX”. "XX" is the qualifier for NPI.	Enter a valid ten-digit NPI number in the Provider ID field when the XX qualifier is used and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DP22, HI12, HX11 Return to SWS CL Layout **MF:** DP22, HI12, HX11 Return to MF CL Layout
III	027	Invalid Employer Identification Number format	The value entered in the Provider ID field is not nine numeric characters long when the Provider ID Qualifier is populated with “24”. “24” is the qualifier for Employer Identification Number.	Enter a valid nine-digit Provider ID in the Provider ID field when the “24” qualifier is used and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DP22, HI12, HX11 Return to SWS CL Layout **MF:** DP22, HI12, HX11 Return to MF CL Layout
III	028	Invalid Social Security Number format	The value entered in the Provider ID field is not nine numeric characters long or contains an invalid value when the Provider ID Qualifier is populated with “34”. “34” is the qualifier for Social Security Number.	Enter a valid nine-digit SSN in the Provider ID field when the “34” qualifier is used and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DP22, HI12, HX11 Return to SWS CL Layout **MF:** DP22, HI12, HX11 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
III	029	Value Not Allowed	The value entered in the data field is not appropriate for submission to ERRP.	Enter a valid value in the data field and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DP09, DP15, DP16, DP17, DP18, DP23, DI10, DI11, DI12, DI13, DI14, DI15, DI16, DI17, DI18, DI19, DI20, DI21, DI22, DI23, DI30, DX08, DX23 Return to SWS CL Layout **MF:** DP09, DP15, DP16, DP17, DP18, DP23, DI10, DI11, DI12, DI13, DI14, DI15, DI16, DI17, DI18, DI19, DI20, DI21, DI22, DI23, DI30, DX08, DX23 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
III	034	Incurred Date is beyond latest allowable date	The date entered in the Date field is after 12/31/2011: • Professional = From Date of Service (DP06) • Institutional = Admission Date (DI06) when Type of Bill (HI10) is “999” or starts with “11” • Institutional = From Date of Service (DI07) when the Type of Bill (HI10) begins with a valid value other than “11” or “999” - valid value includes "000” • Prescription = Filled Date (DX06)	Remove this claim line item from the Claim List if the incurred date is after 12/31/2011. Or, if the Plan Sponsor is certain the claim was incurred on or before 12/31/2011, but it was reported incorrectly on the Claim List, enter the correct date in the From Date of Service (DP06, DI07), Admission Date (DI06), or Filled Date (DX06) field, as applicable. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DP06, DI06, DI07, DX06 Return to SWS CL Layout **MF:** DP06, DI06, DI07, DX06 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
IV	006	Cost Adjustment amount is reported for an individual not included in the Claim List	A Cost Adjustment amount has been reported in the Cost Adjustment Amount field (CA06, CB06) on the Cost Adjustment record type for a Member ID/Member Group ID combination, but no matching claim records with an incurred date before 6/1/2010 (CB), or on or after 6/1/2010 (CA) for the same Member ID/Member Group ID combination are included in the Claim List.	Enter a valid Cost Adjustment value for an individual contained in the current claim list submission. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** CA06, CB06 Return to SWS CL Layout **MF:** CA06, CB06 Return to MF CL Layout
IV	019	Duplicate Cost Adjustment	A duplicate Cost Adjustment Record Type (more than one CA or more than one CB) exists for the same Member ID/Member Group ID combination.	Verify that only one Cost Adjustment (CA) or Cost Adjustment (CB) record type exists for the Member ID/Member Group ID combination, delete multiple or duplicate Cost Adjustment records, and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS**: CA02, CB02 Return to SWS CL Layout **MF**: CA02, CB02 Return to MF CL Layout
IV	020	Cost Adjustment amount greater than Claim Costs	The value in the Cost Adjustment field (CA06), for a Member ID/Member Group ID combination is greater than the summed total of the Item Plan Paid Amount fields (DP24, DI31, and DX24) for all claim types for that same Member ID/Member Group ID combination for claims **incurred on or after 6/1/2010**. The value in the Cost Adjustment field (CB06), for a Member ID/Member Group ID combination is greater than the summed total of the Item Plan Paid Amount fields (DP24, DI31, and DX24) for all claim types for that same Member ID/Member Group ID combination for claims **incurred before 6/1/2010**.	Verify Cost Adjustment amounts on the Claim List, edit as needed, and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** CA06, CB06 Return to SWS CL Layout **MF:** CA06, CB06 Return to MF CL Layout
IV	024	Duplicate Claim	Duplicate Claim (same Record Type, Member ID, Member Group ID, and Claim Number) appears later in the Claim List.	Claim service line items must be grouped together within the Claim List. Resort your Claim List so that all service line items are grouped together with the appropriate claim, delete duplicate claims as applicable, and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS**: HP04, HI04, HX04 Return to SWS CL Layout **MF:** HP04, HI04, HX04 Return to MF CL Layout

Level	Reason Code	Title	What It Means	What You Should Do	Claim List Layouts Navigation
IV	999	Threshold not met	Member ID/Member Group ID combination does not have cumulative claim costs that meet the Cost Threshold.	Remove ineligible member from the Claim List and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** DP24, DI31, DX24 Return to SWS CL Layout **MF:** DP24, DI31, DX24 Return to MF CL Layout
V	017	Number does not match ERRP calculated value	The values submitted in the File Trailer do not match the count/sum calculated from the claim detail lines for the following fields: • **Total Number Of Unique Retirees (FT06)** = Count of UPI's, which is derived from Early Retiree List fields: Member ID, Group ID, gender, and DOB. Note: If there is one unique person (i.e. one UPI) with two Member ID/ Group ID combinations, the unique retiree count must just be one. Even if the early retiree is in two benefit packages that person counts as one for the total unique retirees • **Total Number Of Unique Claims (FT07)** = Count of the total number of HP, HI, and HX records on the Claim List. • **Total Number Of Claim Service Line Records (FT08) =** Count of the total number of DP, DI, and DX records on the Claim List. • **Total Item Plan Paid Amount (FT09) =** Sum of the Item Plan Paid Amount fields (DP24, DI31, DX24) for each claim service line record on the Claim List. • **Total Cost Paid By Early Retiree (FT10) =** Sum of the Cost Paid by Early Retiree fields (HP09, HI09, and HX09) on the Claim List. • **Total Cost Adjustment (FT11) –** Sum of the Cost Adjustment Amount fields (CA06, CB06) for each Cost Adjustment record within the Claim List.	Enter a valid value in the Total Number Of Unique Retirees (FT06), Total Number Of Unique Claims (FT07), Total Number Of Claim Service Line Records (FT08), Total Item Plan Paid Amount (FT09), Total Cost Paid By Early Retiree (FT10), Total Cost Paid By Early Retiree (FT10), or Total Cost Adjustment (FT11) field as applicable to match cumulative totals in the File Trailer and resubmit. The Plan Sponsor must correct all errors associated with this Reason Code and resubmit a complete (error-free) Claim List.	**SWS:** FT06, FT07, FT08, FT09, FT10, FT11 Return to SWS CL Layout **MF:** FT06, FT07, FT08, FT09, FT10, FT11 Return to MF CL Layout