COL	FIELD	LENGTH	NOTES
1	Patient ID **(patient_id)**	11	Use First 10 Characters only for SEER cases.
	SEER Cases (Patient ID)		
1	Registry	2	02 = Connecticut 20 = Detroit 21 = Hawaii 22 = Iowa 23 = New Mexico 25 = Seattle 26 = Utah 42 = Kentucky 43 = Louisiana 44 = New Jersey 87 = Georgia 88 = California
3	Case Number	8	Encrypted SEER Case Number
11	Filler	1	Blank Space
	Non Cancer Patients – Patient ID		
1	HIC ID (9) **(HIC)**	11	Encrypted ID for Non Cancer Patients
12	BENEFICIARY IDENTIFICATION CODE (12) **(BIC)**	2	Relationship between individual and a primary Social Security Administration Beneficiary. (Refer to Appendix table BIC)
14	SSA STANDARD STATE CODE (14) **(state_cd)**	2	State of Beneficiary's residence, SSA Standard Code. (Refer to Appendix table STATE_CD)
16	SSA STANDARD COUNTY CODE (35) **(cnty_cd)**	3	County of Beneficiary's residence, SSA Standard Code.
19	MAILING CONTACT ZIP CODE (42) **(bene_zip)**	9	Beneficiary's mailing address zip code. ***Special Permission Required.**
28	CWF MEDICARE STATUS (46) **(ms_cd)**	2	Medicare entitlement reason 10 = Aged without ESRD 11 = Aged with ESRD 20 = Disabled without ESRD 21 = Disabled with ESRD 31 = ESRD only

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

COL	FIELD	LENGTH	NOTES
30	CLAIM TYPE CODE (7) **(clm_type)**	2	The code used to identify the type of Claim record being processed in NCH. 10 = HHA claim 20 = Non swing bed SNF claim 30 = Swing bed SNF claim 40 = Outpatient claim 41 = Outpatient 'Full-Encounter' claim (available in NMUD) 42 = Outpatient 'Abbreviated – Encounter' (available in NMUD) 50 = Hospice claim 60 = Inpatient claim 61 = Inpatient 'Full-Encounter' claim 62 = Inpatient 'Abbreviated-Encounter' claim (available in NMUD) 71 = RIC O local carrier non-DMEPOS Claim 72 = RIC O local carrier DMEPOS claim 73 = Physician 'Full-Encounter' claim (Available in NMUD) 81 = RIC M DMERC non-DMEPOS claim 82 = RIC M DMERC DMEPOS claim
32	CLAIM FROM DATE (15) **(from_dtm, from_dtd, from_dty)**	8	For Institutional or CWFB Claim, first day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
40	CLAIM THROUGH DATE (16) **(thru_dtm, thru_dtd, thru_dty)**	8	Last day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
48	FI NUMBER (39) **(fi_num)**	5	Assigned by CMS to an Intermediary or Carrier authorized to process claims from Providers or Physician/Suppliers. (Refer to Appendix table FI_NUM for NCH & DME)
53	CARRIER CLAIM ENTRY CODE (30) **(entry_cd)**	1	Generated by Carrier. 1 = *Original debt 3 = Full credit 5 = Replacement debit 9 = Accrete bill history only (Internal; effective 2/22/91) *if claim disposition code = 3, entry code = 1 means original debit was voided.
54	CARRIER CLAIM PAYMENT DENIAL CODE (55) **(pmtdnlcd)**	1	Indicates to whom payment was made, or if a claim was denied. (Refer to Appendix table PMTDNLCD)

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COL	FIELD	LENGTH	NOTES
55	CARRIER CLAIM PROVIDER ASSIGNMENT INDICATOR SWITCH (62) **(asgmntcd)**	1	Whether the provider accepts assignment for the INDICATOR SWITCH claim. A = Assigned claim N = Non-assigned claim
56	DMERC CLAIM ORDERING PHYSICIAN UPIN NUMBER (60) **(ord_upin)**	6	Unique Physician Identification Number (UPIN) number of physician ordering the Part B services/DMEPOS item. **Encrypted data. *Special permission required for unencrypted data.**
62	DMERC CLAIM ORDERING PHYSICIAN NPI NUMBER (61) **(ord_npi)**	10	The NPI assigned to the physician ordering the Part B services/DMEPOS item. The NPI may not be available prior to 7/1/2007. **Encrypted data. *Special permission required for unencrypted data.**
72	LINE HCFA PROVIDER SPEC CODE (117) **(hcfaspec)**	2	HCFA Specialty code used for pricing the service for this line item on the CWFB claim. (Refer to Appendix table HCFASPEC)
74	LINE PROVIDER PART. INDICATOR CODE (118) **(prtcptg)**	1	Code indicating whether or not a provider is participating or accepting assignment for this line item on the Part B claim. (Refer to Appendix table PRTCPTG).
75	LINE PROCESSING INDICATOR CODE (147) **(proindcd)**	2	The code indicating the reason a line item on the CWFB claim was allowed or denied. (Refer to Appendix table PROINDCD).
77	LINE PAYMENT 80/100% CODE (148) **(pay80cd)**	1	The code indicating that the amount shown in the payment field on the CWFB claim represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only. 0 = 80% 1 = 100% 3 = 100% limitation of liability only
78	LINE SERVICE DEDUCTIBLE INDICATOR SWITCH (149) **(dedind)**	1	Switch indicating whether or not the service reflected on the line item on the CWFB claim is subject to deductible. (Refer to Appendix table DED).
79	LINE PAYMENT INDICATOR CODE (150) **(payindcd)**	1	Code that indicates the payment screen used to determine the allowed charge for the line item on the CWFB claim. (Refer to Appendix table PAYINDCD).

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COL	FIELD	LENGTH	NOTES
80	DMERC MILES/TIME/UNITS/SERVICES COUNT (151) **(mtuscnt)**	12.3	The count of the total units associated with services needing unit reporting such as transportation, miles anesthesia time units, number of services, volume of oxygen or blood units. This is a line item on the CWFB claim and is used for both allowed and denied services.
92	DMERC MILES/TIME/UNITS/SERVICES INDICATOR CODE (152) **(mtusind)**	1	Code indicating the units associated with services needing unit reporting on the line item for the CWFB claim. 0 = Values reported as zero 3 = Number of services 4 = Oxygen volume units 6 = Drug Dosage
93	LINE HCPCS CODE (124) **(hcpcs)**	5	Health Care Financing Administration Common Procedure Coding System (HCPCS) code. Procedures, supplies, products or services provided to Medicare Beneficiaries. (Refer to Appendix table HCPCS)
98	LINE HCPCS INITIAL MODIFIER CODE (125) **(mf1)**	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information File)
100	LINE HCPCS SECOND MODIFIER CODE (126) **(mf2)**	2	Second modifier to enable a more specific procedure ID (Carrier Information File)
102	DMERC LINE HCPCS THIRD MODIFIER CODE (127) **(mf3)**	2	Third modifier to the HCPCS procedure code used to process the DMERC line item.
104	DMERC LINE HCPCS FOURTH MODIFIER CODE (128) **(mf4)**	2	Fourth modifier to the HCPCS procedure code used to process the DMERC line item.
106	LINE SUBMITTED CHARGE AMOUNT (143) **(lsubmamt)**	15.2	The amount of submitted charges reported on the line item on the CWFB claim.
121	LINE ALLOWED CHARGE AMOUNT (144) **(lalowamt)**	15.2	The amount of allowed charges reported on the line item on the CWFB claim.
136	LINE HCFA TYPE OF SERVICE CODE (120) **(hcfatype)**	1	Carrier's type of service code (usually different from HCFA's) used for pricing this service. (Refer to appendix table HCFATYPE)
137	LINE PLACE OF SERVICE CODE (121) **(plcsrvc)**	2	Place of service for this procedure code. (Refer to Appendix table PLCSRVC)

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COL	FIELD	LENGTH	NOTES
139	LINE FIRST EXPENSE DATE (122) **(frexpenm, frexpend, frexpeny)**	8	Beginning date of this service. MMDDYYYY
147	LINE LAST EXPENSE DATE (123) **(lsexpenm, lsexpend, lsexpeny)**	8	Ending date for this service. MMDDYYYY
155	LINE SERVICE COUNT (119) **(srvc_cnt)**	12	Count of the total number of services processed.
167	LINE DIAGNSOSIS CODE (155) **(linediag)**	7	ICD – 9-CM code indicating diagnosis supporting this procedure/service.
174	LINE PAYMENT AMOUNT (133) **(linepmt)**	15.2	Amount of payment made to provider and/or beneficiary for the services covered
189	LINE BENEFICIARY PART B DEDUCTIBLE AMOUNT (136) **(ldedamt)**	15.2	The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B deductible on the CWFB claim.
204	LINE BENEFICIARY PRIMARY PAYER PAID AMOUNT (138) **(lprpayat)**	15.2	Amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a CWFB claim.
219	LINE BENEFICIARY PRIMARY PAYER CODE (137) **(lprpaycd)**	1	Specifies a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills. (Refer to Appendix table PRPAY_CD)
220	LINE BENEFICIARY PAYMENT AMOUNT (134) **(lbenpmt)**	15.2	The payment (reimbursement) made to the beneficiary related to the line item service on the non-institutional claim.
235	LINE PROVIDER PAYMENT AMOUNT (135) **(lprvpmt)**	15.2	the payment made to the provider for the line item service on the non-institutional claim.
250	LINE COINSURANCE AMOUNT (139) **(coinamt)**	15.2	The payment made to the provider for the line item service on the non-institutional claim.
265	LINE INTEREST AMOUNT (140) **(lintamt)**	15.2	Amount of interest to be paid on this line item.
280	Carrier Claim Cash Deductible Applied Amount (68) **(dedapply)**	15.2	The amount of the cash deductible as submitted on the claim.

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COL	FIELD	LENGTH	NOTES
295	Carrier Claim Primary Payer Paid Amount (58) **(prpayamt)**	15.2	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.
310	Claim Payment Amount (57) **(pmt_amt)**	15.2	Amount of payment made from the Medicare trust fund for the services covered by the claim record.
325	NCH Claim Allowed Charge Amount (67) **(allowamt)**	15.2	The total allowed charges on the claim (the sum of line item allowed charges).
340	NCH Carrier Claim Submitted Charge Amount (66) **(sbmtamt)**	15.2	The total allowed charges on the claim (the sum of line item allowed charges).
355	NCH Claim Provider Payment Amount (63) **(prov_pmt)**	15.2	The total payments made to the provider for this claim (sum of line item provider payment amounts).
370	Line Primary Payer Allowed Charge Amount (141) **(prpyalow)**	15.2	The primary payer allowed charge amount for the line item service on the non-institutional claim.
385	Carrier Claim HCPCS Year Code (69) **(hcpcs_yr)**	1	The terminal digit of HCPCS version used to code the claim.
386	DMERC LINE SUPPLIER TYPE CODE (115) **(sup_type)**	1	Code identifying the type of supplier furnishing the line item service on the DMERC claim. (Refer to Appendix table SUP_TYPE)
387	DMERC LINE SUPPLIER PROVIDER NUMBER (109) **(suplrnum)**	10	Effective with Version G, billing number assigned to the supplier of the Part B service/DMEPOS by the National Supplier Clearinghouse, as reported on the line item for the DMERC claim.
397	DMERC LINE ITEM SUPPLIER NPI NUMBER (110) **(sup_npi)**	10	The NPI assigned to the supplier of the Part B service/DMEPOS line item. The NPI may not be available prior to 7/1/2007. **Encrypted data. *Special permission required for unencrypted data.**
407	DMERC LINE PROVIDER STATE CODE (114) **(prvstate)**	2	Effective with Version G, the SSA standard state code (converted from the state postal abbreviation) representing the supplier's location, as reported on the DMERC line item. (Refer to Appendix table STATE_CD)
409	LINE NATIONAL DRUG CODE (132) **(ndc_cd)**	11	The National Drug Code identifies the oral anti-cancer drugs.

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COL	FIELD	LENGTH	NOTES
420	CLAIM LINE COUNT (26) **(clinecnt)**	2	The count of the number of line items on the carrier claim.
422	LINK NUMBER (23) **(link_num)**	10	A system generated by CMS number used to keep records/segments belonging to a specific claim together.
432	DAILY PROCESS DATE (22) (**daily_dtm, daily_dtd, daily_dty)**	8	The date the claim record was produced by CMS' CWFMQA system (used for internal editing purposes). MMDDYYYY
440	PRINCIPAL DIAGNOSIS CODE (53) **(pdgns_cd)**	7	Beneficiaries' principle diagnosis code.
447	CLAIM DIAGNOSIS CODE COUNT (81) **(cdgncnt)**	2	The count of the number of diagnosis codes (both principal and secondary) reported on a DMERC claim. The purpose of this count is to indicate how many claim diagnosis code trailers are present.
449	CLAIM DIAGNOSIS CODES (106) **(dgnscd1-dgnscd12)**	12*7	Up to twelve 5 digit ICD-9 diagnosis codes. For persons with less than twelve codes the columns are blank filled.
533	BETOS CODE (129) **(betos)**	3	Berenson-Eggers type of service (Betos) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. (Refer to Appendix table BETOS)
536	CARRIER CLAIM BENEFICIARY PAID AMOUNT (65) **(benepaid)**	15.2	The amount paid by the beneficiary for the non-institutional Part B services.
551	CWF CLAIM ACCRETION DATE (18) **(acrtn_dtm, acrtn_dtd, acrtn_dty)**	8	The date the claim record is accreted (posted/ processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal intermediary or carrier. MMDDYYYY
559	NCH CLAIM BENEFICIARY PAYMENT AMOUNT (64) **(nchben_pmt)**	15.2	The total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.)
574	LINE ADDITIONAL CLAIM DOCUMENTATION INDICATOR CODE (156) **(docindcd)**	1	Code indicating additional claim documentation was submitted. (Refer to Appendix table DOCINDCD).

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COL	FIELD	LENGTH	NOTES
575	NCH CATEGORY EQUATABLE BENEFICIARY IDENTIFICATION CODE (11) **(eq_bic)**	2	The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner.
577	CLM TYPE (SAME AS CLM_TYPE) (7) **(clm_type2)**	2	The code used to identify the type of claim record being processed in NCH.
579	LINE WAIVER OF PROVIDER LIABILITY SWITCH (159) **(prov_liab)**	1	The switch indicating the beneficiary was notified that the item, reported as a DMERC line item, may not be considered medically necessary and has agreed in writing to pay for the item.
580	LINE DME PURCHASE PRICE AMOUNT (146) **(dmepcamt)**	15.2	The amount representing the lower of fee schedule for purchase of new or used DME, or actual charge.
595	LINE PROVIDER TAX NUMBER (116) **(tax_num)**	10	Social security number or employee identification number of physician/supplier used to identify to whom payment is made for the line item service on the non-institutional claim. ***Special Permission Required.**
605	LINE PRICING STATE CODE (111) **(price_cd)**	2	The state code for the pricing the service. (Refer to Appendix table STATE_CD).
607	LINE PRICING ZIP CODE (112) **(prcngzip)**	9	The zip code used to identify where the supply/item was rendered. The pricing state code and the pricing zip code will be used in pricing DMEPOS claims. ***Special Permission Required.**
616	YEAR OF THE FILE	4	Year of the file.
620	RECORD COUNT **(rec_count)**	3	Record count for claim
623	Filler	1	

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