Connecticut APCD Support Documentation

Data Submission Companion Guide

Version 1.3

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Effective: October 1, 2023

For assistance or for technical questions, please contact Onpoint's intake and support team for the CT APCD at ct-support@onpointhealthdata.org or call our Data Operations team at 207-623-2555.

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Change Log

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#	Tab	Field ID	Element Common Name	Update Type	Update Description	Effective Date
1	General File Specifications	N/A	N/A	Requirements updated	Notes have been updated to request the reporting of both partially and fully denied claims for all claim types.	3/29/2023
2	Header	HD004	Type of File	Requirements updated	A new value of 'DC' has been added to accommodate the collection of dental claims.	3/29/2023
3	Trailer	TR004	Type of File	Requirements updated	A new value of 'DC' has been added to accommodate the collection of dental claims.	3/29/2023
4	Eligibility	ME021	Race (1)	Requirements updated	This field has been updated to accommodate the collection of new race reporting standards from the CCIP.	3/29/2023
5	Eligibility	ME021	Race (1)	Length expanded	This field's maximum length has been expanded from 2 to 4 to accommodate the reporting of CCIP codes.	3/29/2023
6	Eligibility	ME022	Race (2)	Requirements updated	This field has been updated to accommodate the collection of new race reporting standards from the CCIP.	3/29/2023
7	Eligibility	ME022	Race (2)	Length expanded	This field's maximum length has been expanded from 2 to 4 to accommodate the reporting of CCIP codes.	3/29/2023
8	Eligibility	ME023	Race (Other)	Requirements updated	This field has been updated to accommodate the collection of new race reporting standards from the CCIP.	3/29/2023
9	Eligibility	ME025	Ethnicity (1)	Requirements updated	This field has been updated to accommodate the collection of new ethnicity reporting standards from the CCIP.	3/29/2023
10	Eligibility	ME026	Ethnicity (2)	Requirements updated	This field has been updated to accommodate the collection of new ethnicity reporting standards from the CCIP.	3/29/2023
11	Eligibility	ME027	Ethnicity (Other)	Requirements updated	This field has been updated to accommodate the collection of new ethnicity reporting standards from the CCIP.	3/29/2023
12	Eligibility	ME033	Member Language Preference (1)	Type changed	This field has been updated to accommodate the collection of new language reporting standards from the ISO.	3/29/2023
13	Eligibility	ME033	Member Language Preference (1)	Requirements updated	This field has been updated to accommodate the collection of new language reporting standards from the ISO.	3/29/2023
14	Eligibility	ME034	Member Language Preference (Other)	Requirements updated	This field has been updated to accommodate the collection of new language reporting standards from the ISO.	3/29/2023
15	Eligibility	ME045	Purchased through Exchange Indicator	Requirements updated	This field's denominator has been updated to all records.	3/29/2023
16	Eligibility	ME072	Family Size	Requirements updated	This field's denominator has been updated to all records.	3/29/2023
17	Eligibility	ME120	Actuarial Value	Requirements updated	This field's denominator has been updated to all records.	3/29/2023
18	Eligibility	ME121	Exchange Metallic Tier Code	Requirements updated	This field's denominator has been updated to all records.	3/29/2023
19	Eligibility	ME127	Billable Member Flag	Requirements updated	This field's denominator has been updated to all records.	3/29/2023
20	Eligibility	ME132	Monthly Premium Amount	Requirements updated	This field's denominator has been updated to all records.	3/29/2023
21	Medical Claims	MC124	Denial Reason	Requirements updated	This field has been updated to accommodate the collection of denied claims reporting standards from X12.	3/29/2023
22	Pharmacy Claims	PC034	Days' Supply	Length expanded	This field's maximum length has been expanded from 3 to 4 to accommodate the reporting of reversals.	3/29/2023
23	Pharmacy Claims	PC117	Denial Reason	Requirements updated	This field has been updated to accommodate the collection of denied claims reporting standards from NCPDP.	3/29/2023
24	Dental Claims	N/A	N/A	Layout added	New dental claims layout has been added as a new tab.	3/29/2023
25	Dental Claims	DC095	Denial Reason	Requirements updated	This field has been updated to accommodate the collection of denied claims reporting standards from X12.	3/29/2023
26	All Layout Tabs	N/A	N/A	Column removed	The "Date Modified" column has been removed from all layout tabs.	3/29/2023

Basic Rules

1	**Header and trailer records.** Each submission regardless of type — eligibility, medical claims, pharmacy claims, dental claims, and provider — must begin with a header record and end with a trailer record. (Example header, eligibility, and trailer records for a test submission of 4,350 records for June 2021 are included below.)
2	**Submitting multiple months of claims data at once.** You may submit multiple complete months of data with one pair of header and trailer records by indicating the earliest date in HD005 and TR005 and the latest date in HD006 and TR006. Note that each month of data will be evaluated for completeness in its own right and will pass or fail as if it were submitted as a single month of data. If a submitter provides a single file with six months of data for January through June and all months except May pass all checks, May will be rejected and the submitter will be asked to correct and resend only May data. No partially complete months are allowed. (**Note:** Since eligibility files must include all members active within the preceding 12 months, each month's submission should include one record per member for that reporting period. Additional records for a member would be warranted if their information (e.g., product code) changed during the reporting period.)
3	**Indicating missing data.** When two or more pipes appear together, there is no data for the field. For example, in the eligibility file example below (mock data for file type = ME), the lack of data between the pipes highlighted in yellow indicates fields that are unavailable for reporting. Please note that the header data is in purple, the eligibility data is in blue, and the trailer data is in green. HD|CTC0000Z||ME|20210601|20210630|4350||1.2 CTC0000Z|PS|2021|06|CTZ1245889|18|M|19520708|HARTFORD|CT|06101|Y|N|3|||||CROSBY|FRANKLIN||CROSBY|FRANKLIN||ME CTC0000Z|PS|2021|06|CTZ1245889|01|F|19550328|BRIDGEPORT|CT|06601|Y|N|3||||||CROSBY|FRANKLIN||CROSBY|LUCY||ME CTC0000Z|PS|2021|06|CTZ003456F|18|F|19800326|HARTFORD|CT|06103|Y|N|3||||||PLATT|AMELIA|J|PLATT|AMELIA|J|ME CTC0000Z|PS|2021|06|CTZ003456F|19|F|20060603|MILFORD|CT|06460|Y|N|3||||||PLATT|AMELIA|J|PLATT|ANN|T|ME CTC0000Z|PS|2021|06||18|M|19630407|WINSTED|CT|06063|Y|N|3||||||OROURKE|JAMES||OROURKE|JAMES||ME CTC0000Z|PR|2021|06||18|M|19750504|MIDDLETOWN|CT|06457|Y|N|3||||||LAMOREAU|JOHN||LAMOREAU|JOHN||ME TR|CTC0000Z||ME|20210601|20210630|20210724
4	**No empty rows.** Please note that there should be no empty rows separating either the header or the trailer from the reported data.
5	**No punctuation.** Punctuation should not be included in the reporting of any names, including the names of drugs. For example, a last name of O'Rourke should be reported as 'OROURKE'.
6	**No decimal points.** Decimal points should not be included in the reporting of financial fields. For example, a dollar amount of $120.56 should be reported as '12056'.
7	**Date formats.** Dates, unless otherwise specified, should be reported using the 8-digit format of YYYYMMDD. For example, January 18, 2021, should be reported as '20210118'.

File Requirements

File Type	Covered Parties	Required Frequency	Specific Deadline	Notes
Eligibility	All	Monthly	Within 30 business days of the end of the preceding calendar month	
Medical Claims	All	Monthly	Within 30 business days of the end of the preceding calendar month	• Medical claims submissions must include all claims adjudicated during the reported time period. • All available claims should be reported, including partially and fully denied claims. • One record must be submitted for each service adjudicated during the period reported in the header and trailer records. A consistent date must be used as the basis for claims submission to ensure that all records are reported each month. The Paid Date field (MC017) should be used for this purpose. All dates reported in this field should fall within the period beginning/ending dates reported in the header and trailer (HD005/TR005 and HD006/TR006). • Submissions must cover full months of data; partial months must not be reported.
Pharmacy Claims	All	Monthly	Within 30 business days of the end of the preceding calendar month	• All available claims should be reported including partially and fully denied claims. • One record must be submitted for each service adjudicated during the period reported in the header and trailer records. A consistent date must be used as the basis for claims submission to ensure that all records are reported each month. The Paid Date field (PC017) should be used for this purpose. All dates reported in this field should fall within the period beginning/ending dates reported in the header and trailer (HD005/TR005 and HD006/TR006). • Submissions must cover full months of data; partial months must not be reported.

Dental Claims	All	Monthly	Within 30 business days of the end of the preceding calendar month	• Dental claims submissions must include all claims adjudicated during the reported time period. • All available claims should be reported including partially and fully denied claims. • One record must be submitted for each service adjudicated during the period reported in the header and trailer records. A consistent date must be used as the basis for claims submission to ensure that all records are reported each month. The Paid Date field (DC017) should be used for this purpose. All dates reported in this field should fall within the period beginning/ending dates reported in the header and trailer (HD005/TR005 and HD006/TR006). • Submissions must cover full months of data; partial months must not be reported.
Provider	All	Monthly	Within 30 business days of the end of the preceding calendar month	• One record must be submitted for each variation in a provider's information during the period reported in the header and trailer records. • Submissions must include information for all providers who rendered services reported in your claims data submissions. • The provider file should include all Connecticut-based providers, providers outside of Connecticut who have been reported in the claims files and PCPs reported in the eligibility file.

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Field Specifications: Header & Trailer

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Header Record

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
1	HD001	Record Type	Text	2	Header record identifier	Report 'HD' here. Indicates the beginning of the header elements of the file.	Mandatory	100.00%	Administrative
2	HD002	Submitter Code	Text	8	Header submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, TR002, and each file's first field (**001).	Mandatory	100.00%	Administrative
3	HD003	National Plan ID	Text	10	Header CMS National Plan Identification Number (Plan ID)	Do not report any value here until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	Situational	0.00%	Administrative
4	HD004	Type of File	Text	2	Header file type	This field must be coded with the two-character abbreviation that indicates the type of data being submitted. The only valid codes for this field are: ME = Member eligibility file MC = Medical claims PC = Pharmacy claims DC = Dental claims PV = Provider file The value reported here must match across the following fields: HD004, TR004, and each file's last field (**899).	Mandatory	100.00%	Administrative
5	HD005	Period Beginning Date	Full Date - Integer	8	Header period start date	Report the date of the first day of the reported submission period in YYYYMMDD format. This date is the first day of the month for the reporting period and must be repeated in TR005.	Mandatory	100.00%	Administrative
6	HD006	Period Ending Date	Full Date - Integer	8	Header period end date	Report the date of the last day of the reported submission period in YYYYMMDD format. This date is the last day of the month for the reporting period and must be repeated in TR006.	Mandatory	100.00%	Administrative
7	HD007	Record Count	Integer	10	Header record count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters. If the number of records within the submission does not equal the number reported in this field, the submission will fail. The record count should not include the header and trailer records.	Mandatory	100.00%	Administrative
8	HD008	Comments	Text	80	Header carrier comments	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	Optional	0.00%	Administrative
9	HD009	APCD Version Number	Decimal - Numeric	3	Header DSG version number	Report the DSG version number included on the cover page of this companion guide in #.# format, including the decimal point in the reported value. If the APCD Version Number reported in this field is not accurate, your submission will fail.	Mandatory	100.00%	Administrative

Trailer Record

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
1	TR001	Record Type	Text	2	Trailer record identifier	Report 'TR' here. Indicates the beginning of the trailer elements of the file.	Mandatory	100.00%	Administrative
2	TR002	Submitter Code	Text	8	Trailer submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, TR002, and each file type's **001 field.	Mandatory	100.00%	Administrative
3	TR003	National Plan ID	Text	10	Trailer CMS National Plan Identification Number (Plan ID)	Report as null until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	Situational	0.00%	Administrative
4	TR004	Type of File	Text	2	Trailer file type	This field must be coded with the two-character abbreviation that indicates the type of data being submitted. The only valid codes for this field are: ME = Member eligibility file MC = Medical claims PC = Pharmacy claims DC = Dental claims PV = Provider file The value reported here must match across the following fields: HD004, TR004, and each file type's **899 field.	Mandatory	100.00%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
5	TR005	Period Beginning Date	Full Date - Integer	8	Trailer period start date	Report the date of the first day of the reported submission period in YYYYMMDD format. This date is the first day of the month for the reporting period and must be repeated in HD005.	Mandatory	100.00%	Administrative
6	TR006	Period Ending Date	Full Date - Integer	8	Trailer period end date	Report the date of the last day of the reported submission period in YYYYMMDD format. This date is the last day of the month for the reporting period and must be repeated in HD006.	Mandatory	100.00%	Administrative
7	TR007	Date Processed	Full Date - Integer	8	Trailer processed date	Report the full date that the submission was compiled by the submitter in YYYYMMDD format.	Mandatory	100.00%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
1	ME001	Submitter Code	Text	8	Submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match the value reported across all file types in the following fields: HD002, TR002, ME001, MC001, PC001, DC001, and PV001. Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter. Note, too, that the first two characters of the submitter code are used to indicate the client while the third character designates the type of submitter. For Connecticut's APCD collection, the only valid prefixes are: CTC = Commercial carrier CTG = Governmental agency CTT = Third-party administrator / pharmacy benefits manager	All	100.0%	Administrative
2	ME002	National Plan ID	Text	10	CMS National Plan Identification Number (Plan ID)	Do not report any value here until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	All	0.0%	
3	ME003	Insurance Type / Product Code	Look-up Table - Text	2	Type/product identification code	Report the code that defines the type of insurance under which this member's eligibility is maintained. The only valid codes for this field are: 9 = Self-pay 11 = Other Non-Federal Programs (use of this value requires disclosure to Onpoint prior to submission) 12 = Preferred Provider Organization (PPO) 13 = Point of Service (POS) 14 = Exclusive Provider Organization (EPO) 15 = Indemnity Insurance 16 = Health Maintenance Organization (HMO) Medicare Risk (use to report Medicare Part C/Medicare Advantage Plans) 17 = Dental Maintenance Organization (DMO) 96 = Husky Health A 97 = Husky Health B 98 = Husky Health C 99 = Husky Health D AM = Automobile Medical CH = Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (now TRICARE) DS = Disability HM = Health Maintenance Organization LM = Liability Medical MA = Medicare Part A (Medicare Fee for Service only) MB = Medicare Part B (Medicare Fee for Service only) MC = Medicaid MD = Medicare Part D OF = Other Federal Program (use of this value requires disclosure to Onpoint prior to submission) TV = Title V A = Veterans Affairs Plan WC = Workers' Compensation ZZ = Mutually Defined (use of this value requires disclosure to Onpoint prior to	All	96.0%	837/2000B/SBR/ /09
4	ME004	Year	Date Period - Integer	4	Reporting year of eligibility	Use this field to report the year for which eligibility is reported in this submission in YYYY format. If reporting previous year's data, the year reported here will not match current year. Do not report a future year here.	All	100.0%	Administrative
5	ME005	Month	Text	2	Reporting month of eligibility	Use this field to report the month for which eligibility is reported in this submission expressed in numerical MM format from 01 to 12. The leading zero is required for reporting January through September files.	All	100.0%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
6	ME006	Insured Group or Policy Number	Text	30	Group/policy number	Use this field to report the group or policy number. Notes: The value reported for this field should be reported consistently in the Insured Group or Policy Number field across file types: ME006, MC006, PC006, and DC006. This is not the number that uniquely identifies the subscriber. If a policy is sold to an individual as a non-group policy, report with a value of 'IND'. This principle pertains to all claim types: commercial, Medicaid, and Medicare.	All	99.0%	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02
7	ME007	Coverage Level Code	Look-up Table - Text	3	Benefit coverage level code	Use this field to report the benefit level of coverage. The only valid codes for this field are: CHD = Children Only DEP = Dependents Only ECH = Employee and Children ELF = Employee and Life Partner EMP = Employee Only ESP = Employee and Spouse FAM = Family IND = Individual SPC = Spouse and Children SPO = Spouse Only UNK = Unknown	All	99.0%	271/2110C/EB/ /02, 271/2110D/EB/ /02
8	ME008	Subscriber Social Security Number	Text	9	Subscriber's Social Security Number	Report the subscriber's Social Security number. Do not code using hyphens. If not available, do not report any value here. If this field is not populated, ME009 must be populated. Notes: The value reported for this field should be reported consistently in the Subscriber Social Security Number field across file types: ME008, MC007, PC007, DC007. This field will not be passed into the analytic file.	All	85.0%	271/2100C/REF/SY/02
9	ME009	Plan-Specific Contract Number	Text	30	Contract number	Report the plan-assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents. If this field is not populated, ME008 must be populated. Notes: The value reported for this field should be reported consistently in the Plan-Specific Contract Number across file types: ME009, MC008, PC008, and DC008.	All	95.0%	271/2100C/NM1/MI/09
10	ME010	Member Sequence Number	Text	20	Member's contract sequence number	Report the unique number / identifier of the member within the contract.	All	99.0%	N/A
11	ME011	Member Social Security Number	Text	9	Member Social Security number	Report the member's Social Security number. Do not code using hyphens. If not available, report as null. Notes: The value reported for this field should be reported consistently in the Member Social Security Number field across file types: ME011, MC010, PC010, DC010. This field will not be passed into the analytic file.	All	68.0%	271/2100C/REF/SY/02, 271/2100D/REF/SY/02

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
12	ME012	Member Relationship Code	Look-up Table - Text	2	Member to subscriber relationship code	Report the value that defines the member's relationship to the subscriber. The only valid codes for this field are: 1 = Spouse 4 = Grandfather or Grandmother 5 = Grandson or Granddaughter 7 = Nephew or Niece 10 = Foster Child 12 = Other Adult 15 = Ward 17 = Stepson or Stepdaughter 18 = Self 19 = Child 20 = Employee 21 = Unknown 22 = Handicapped Dependent 23 = Sponsored Dependent 24 = Dependent of a Minor Dependent 29 = Significant Other 32 = Mother 33 = Father 34 = Other Adult 36 = Emancipated Minor 39 = Organ Donor 40 = Cadaver Donor 41 = Injured Plaintiff 43 = Child Where Insured Has No Financial Responsibility 53 = Life Partner 76 = Dependent	All	98.0%	271/2100C/INS/Y/02, 271/2100D/INS/N/02
13	ME013	Member Gender Code	Look-up Table - Text	1	Member's gender	Report the member's gender as reported on enrollment form in alpha format. Notes: The value reported for this field should be reported consistently in the Member Gender Code field across file types: ME013, MC012, PC012, and DC012. The only valid codes for this field are: F = Female M = Male U = Unknown	All	100.0%	271/2100C/DMG/ /03, 271/2100D/DMG/ /03
14	ME014	Member Date of Birth	Full Date - Integer	8	Member's date of birth	Use this field to report the date on which the member was born in YYYYMMDD format. Notes: The value reported for this field should be reported consistently in the Member Date of Birth field across file types: ME014, MC013, PC013, and DC013.	All	99.0%	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02
15	ME015	Member City	Text	30	City name of the member	Report the city name of the member.	All	99.0%	271/2100C/N4/ /01, 271/2100D/N4/ /01
16	ME016	Member State	External Code Source 2 - Text	2	State/province of the member	Use this field to report the member's state using the two-character abbreviation as defined by the U.S. Postal Service.	All	99.0%	271/2100C/N4/ /02, 271/2100D/N4/ /02
17	ME017	Member ZIP Code	External Code Source 2 - Text	9	ZIP code of the member	Use this field to report the ZIP code associated with the member's residence. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	99.0%	271/2100C/N4/ /03, 271/2100D/N4/ /03
18	ME018	Medical Coverage Flag	Look-up Table - Integer	1	Indicator - Medical option	Use this field to report whether or not the member's plan with your organization included coverage for medical services. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable Notes: Onpoint will be considering values of '3', '4', and '5' to be the same as a value of '2' (No). Only values of '1' and '2' are valid in this field.	All	100.0%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
19	ME019	Pharmacy Coverage Flag	Look-up Table - Integer	1	Indicator - Pharmacy option	Use this field to report whether or not the member's plan with your organization included coverage for prescription drugs. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable Notes: Onpoint will be considering values of '3', '4', and '5' to be the same as a value of '2' (No). Only values of '1' and '2' are valid in this field.	All	100.0%	Administrative
20	ME020	Dental Coverage Flag	Look-up Table - Integer	1	Indicator - Dental option	Use this field to report whether or not the member's plan with your organization included coverage for dental services. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable Notes: Onpoint will be considering values of '3', '4', and '5' to be the same as a value of '2' (No). Only values of '1' and '2' are valid in this field.	All	100.0%	Administrative
21	ME021	Race (1)	External Code Source: CCIP - Text	4	Member's self-identified race (1)	Report the member's self-identified race (1) here using the four-character CCIP Race Code or CCIP Race/Ethnicity Code, which can be located in the standards documentation posted by OHS at the following URL: https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/REL/PA-21-35-REL-Data-Collection-Standards.pdf. Notes: If unable to report the updated CCIP codes, please continue to report using the historical race codes included below: R1 = American Indian / Alaska Native R2 = Asian R3 = Black / African American R4 = Native Hawaiian or other Pacific Islander R5 = White R9 = Other race UN = Unknown / Not specified	All	3.0%	N/A
22	ME022	Race (2)	External Code Source: CCIP - Text	4	Member's self-identified race (2)	Report the member's self-identified race (2) here using the four-character CCIP Race Code or CCIP Race/Ethnicity Code, which can be located in the standards documentation posted by OHS at the following URL: https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/REL/PA-21-35-REL-Data-Collection-Standards.pdf. Notes: If unable to report the updated CCIP codes, please continue to report using the historical race codes included below: R1 = American Indian / Alaska Native R2 = Asian R3 = Black / African American R4 = Native Hawaiian or other Pacific Islander R5 = White R9 = Other race UN = Unknown / Not specified	All	2.0%	N/A
23	ME023	Race (Other)	Text	15	Member's self-identified other race	Report the member's self-identified race when ME021 or ME022 is entered as 'R600' through 'R603' or 'C800' through 'C803' (some other race). If not applicable, do not report any value here.	Required when ME021 or ME022 = R600-R603 or C800-C803	99.0%	N/A
24	ME024	Hispanic Indicator	Look-up Table - Integer	1	Indicator - Hispanic status	Use this field to report whether or not the member identified as Hispanic. The code value '3' (Unknown), should be used only when the member answers "unknown" or refuses to answer. Report as null if data has not been collected. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	3.0%	N/A

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
25	ME025	Ethnicity (1)	External Code Source: CCIP - Text	6	Member's self-identified ethnicity (1)	Report the member's self-identified ethnicity (1) using the four-character CCIP ethnicity code, which can be located in the standards documentation posted by OHS at the following URL: https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/REL/PA-21-35-REL-Data-Collection-Standards.pdf. Report as null if data has not been collected. Notes: If unable to report the updated CCIP codes, please continue to report using the historical six-character Unique Identifier, including all five digits and the hyphen (e.g., '2149-3') as maintained by the CDC at the following URL: https://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf.	All	3.0%	N/A
26	ME026	Ethnicity (2)	External Code Source: CCIP - Text	6	Member's self-identified ethnicity (2)	Report the member's self-identified ethnicity (2) using the four-character CCIP Ethnicity code, which can be located in the standards documentation posted by OHS at the following URL: https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/REL/PA-21-35-REL-Data-Collection-Standards.pdf. Report as null if data has not been collected. Notes: If unable to report the updated CCIP codes, please continue to report using the historical six-character Unique Identifier, including all five digits and the hyphen (e.g., '2149-3') as maintained by the CDC at the following URL: https://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf.	All	2.0%	N/A
27	ME027	Ethnicity (Other)	Text	20	Member's self-identified other ethnicity	Report the member's self-identified ethnicity when ME025 or ME026 is reported as 'E800' through 'E803' (other ethnicity), If not applicable, do not report any value here.	Required when ME025 or ME026 = E801-E803	99.0%	N/A
28	ME028	Primary Insurance Indicator	Look-up Table - Integer	1	Indicator - Primary insurance coverage	Use this field to report whether or not this coverage is primary. Products, plans, or benefits that only cover copays, coinsurance, and deductibles (gap coverage) report a value of '2' (No) here. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	N/A
29	ME029	Coverage Type Code	Look-up Table - Text	3	Type of coverage code	Report the code that defines the type of insurance policy under which the enrollee is covered. The only valid codes for this field are: ASW = Self-funded plans that are administered by a third-party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage ASO = Self-funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess, insurance coverage STN = Short-term, non-renewable health insurance UND = Plans underwritten by the insurer OTH = Any other plan. Insurers using this code shall obtain prior approval.	Required when ME134 = 1 or 2	98.0%	N/A

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
30	ME030	Market Category Code	Look-up Table - Text	4	Group size code / market category code	Report the code to indicate group size consistent with Connecticut insurance law and regulations. The only valid codes for this field are: IND = Policies sold and issued directly to individuals (i.e., a non-group policy) FCH = Policies sold and issued directly to individuals on a franchise basis GCV = Policies sold and issued directly to individuals as group conversion policies GS1 = Policies sold and issued directly to employers having exactly one employee GS2 = Policies sold and issued directly to employers having between two and nine employees GS3 = Policies sold and issued directly to employers having 10–25 employees GS4 = Policies sold and issued directly to employers having 26–50 employees GS5 = Policies sold and issued directly to employers having 1–50 employees GLG0 = Policies sold and issued directly to employers having 51 or more employees GLG1 = Policies sold and issued directly to employers having 51–100 employees GLG2 = Policies sold and issued directly to employers having 101–250 employees GSA = Policies sold and issued directly to small employers through a qualified association trust GLG3 = Policies sold and issued directly to employers having 251–500 employees GLG4 = Policies sold and issued directly to employers having 501 or more employees GSA = Policies sold and issued directly to small employers through a qualified association trust	All	100.0%	N/A
31	ME031	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
32	ME032	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
33	ME033	Member Language Preference (1)	External Code Source: ISO 639-2 / 639-5 Identifier Set - Text	3	Member's self-identified verbal language preference	Report the member's self-identified spoken language preference using the 3-character ISO 639-2 / 639-5 Identifier Set code, which can be located in the standards documentation posted by OHS at the following URL: https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/REL/PA-21-35-REL-Data-Collection-Standards.pdf. Notes: If unable to report using the ISO codes, please continue to report using the historical three-character language identifier.	All	3.0%	N/A
34	ME034	Member Language Preference (Other)	Text	20	Member's self-identified other language preference	Report the other language that the member has identified as preferred. Do not report any value if no other language was identified.	All	2.0%	N/A
35	ME035	Medical Home Indicator	Look-up Table - Integer	1	Medical home indicator	Use this field to report whether or not the member had a medical home on record for this coverage period. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
36	ME036	Submitter-Specific Medical Home ID	Text	30	Health Care Home ID	Report the submitter-assigned medical home number. It is anticipated that this will be the same number used when reporting the rendering provider. Do not report any data here if not applicable. The number of the member's healthcare home must also be reported in the Provider File using the Submitter-Specific Provider ID field (PV002).	Required when ME035 = 1	90.0%	Administrative
37	ME037	Medical Home Tax ID	Text	9	Health Care Home EIN	Report the federal Tax Identification Number of the medical home here. If there is no medical home to report, do not report any value. Do not use hyphen or alpha prefix.	Required when ME035 = 1	90.0%	Administrative
38	ME038	Medical Home NPI	External Code Source NPPES - Text	10	National Provider Identifier (NPI) of the Health Care Home Provider	Report the National Provider Identifier (NPI) for the entity or individual serving as the medical home. If there is no medical home to report, do not report any value.	Required when ME035 = 1	10.0%	Administrative
39	ME039	Medical Home Name	Text	60	Name of Health Care Home	Report the full name of the medical home. If the medical home is an individual, report in the format of last name, first name, and middle initial with no punctuations. If there is no medical home to report, do not report any value.	Required when ME035 = 1	90.0%	Administrative
40	ME040	Submitter-Supplied Product ID	Text	30	Product identification	Report the submitter-assigned identifier for the product. This element is used to understand product and eligibility attributes of the member/subscriber as applied to this record. Please note: Reporting entities must provide Onpoint with an Excel file that includes your Submitter-Specific codes and descriptions prior to submission. Notes: If no product IDs are assigned, please report using the following default value: '9999999999'.	All	100.0%	Administrative
41	ME041	Coverage Effective Date	Integer	8	Start date	Report the date on which the member was enrolled in YYYYMMDD format.	All	100.0%	Administrative
42	ME042	Coverage Termination Date	Integer	8	End date	Report the date on which the member was disenrolled in YYYYMMDD format. If the member was not disenrolled at the end of the current month, then report as null.	All	10.0%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
43	ME043	Member Street Address (1)	Text	50	Street address of the member	Use this field to report the first line of the member's street address.	All	98.0%	271/2100C/N3/ /01, 271/2100D/N3/ /01
44	ME044	Member Street Address (2)	Text	50	Secondary street address of the member	Use this field to report the second line of the member's street address, which may include apartment number, suite identifier, or other secondary information.	All	2.0%	271/2100C/N3/ /02, 271/2100D/N3/ /02
45	ME045	Purchased through Exchange Indicator	Look-up Table - Integer	1	Indicator – CT Health Insurance Exchange	Use this field to report whether or not the policy for this eligibility record was purchased through the CT health insurance exchange. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
46	ME046	Member PCP ID	Text	30	Member's PCP ID	Report the identifier of the member's PCP. The value in this field must also be reported in the Provider File using the Submitter-Specific Provider ID field (PV002). Report a value of 'UNKNOWN' when PCP is unknown or 'NA' if the eligibility does not require a PCP.	All	98.0%	834/2310/NM1/P3/SV/09
47	ME047	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
48	ME048	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
49	ME049	Member Deductible Amount	Decimal,2	10	Annual maximum out-of-pocket member deductible across all benefit types	Report the maximum amount of the member's annual deductible across all benefit types (medical, pharmacy, vision, behavioral health, etc.) before certain services are covered. Report only in-network deductible here if plan has an in-network vs. out-of-network deductible methodology. Report '0' when there is no deductible applied to all benefits for this eligibility. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	100.0%	834/2100A/AMT/D2/02
50	ME050	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
51	ME051	Behavioral Health Benefit Indicator	Look-up Table - Integer	1	Indicator - Behavioral health option	Use this field to report whether or not behavioral/mental health services were a covered benefit. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
52	ME052	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
53	ME053	Disease Management Enrollee Indicator	Look-up Table - Integer	1	Indicator - Chronic illness management	Use this field to report whether or not the member was enrolled in a disease management program. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
54	ME054	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
55	ME055	Business Type Code	Look-up Table - Integer	1	Business type	Report the value that defines the submitter's line of business for this line of eligibility. The only valid codes for this field are: 1 = Risk Holder 2 = Third-Party Administrator (TPA) 3 = Delegated Business Administrator (DBA) 4 = Pharmacy Benefit Manager (PBM) 5 = Dental Benefit Manager (DBM) 6 = Computer Service Organization (CSO) 7 = Other 0 = Unknown / Not Applicable	All	100.0%	Administrative
56	ME056	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
57	ME057	Member Date of Death	Full Date - Integer	8	Member's date of death	Report the date on which the member expired in YYYYMMDD format. If still alive or date of death is unknown, report as null.	All	0.0%	Administrative
58	ME058	Subscriber Street Address (1)	Text	50	Street address of the subscriber	Use this field to report the subscriber's street address.	All	98.0%	271/2100C/N3/ /01

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
59	ME059	Disability Indicator	Look-up Table - Integer	1	Indicator - Disability	Use this field to report whether or not disability applied to this record. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
60	ME060	Employment Status Code	Look-up Table - Text	1	Employment status code	Report the code that defines the employment status of the subscriber. The only valid codes for this field are: A = Active I = Involuntary Leave O = Orphan P = Pending R = Retiree S = Student Z = Unemployed U = Unknown	All	100.0%	Administrative
61	ME061	Student Status Indicator	Look-up Table - Integer	1	Indicator - Student status	Use this field to report whether or not the member was a student. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
62	ME062	Marital Status Code	Look-up Table - Text	1	Marital status code	Report the member's marital status here. The only valid codes for this field are: C = Common Law Married D = Divorced M = Married P = Domestic Partnership S = Never Married W = Widowed X = Legally Separated U = Unknown	All	100.0%	834/2100A/DMG/ /04
63	ME063	Benefit Status Code	Look-up Table - Text	1	Benefit status code	Report the code that defines the status of the benefits for the member. If member's benefits have been terminated, report as 'U' (Unknown). The only valid codes for this field are: A = Active C = COBRA P = Pending S = Surviving Insured T = TEFRA U = Unknown	All	100.0%	834/2000/INS/ /05
64	ME064	Employee Type Code	Look-up Table - Text	1	Employee type code	Report the code that defines the subscriber's type of employment. The only valid codes for this field are: H = Hourly Q = Seasonal S = Salaried T = Temporary U = Unknown	Required when ME060 = A or P	100.0%	Administrative
65	ME065	Member Date of Retirement	Integer	8	Employee's date of retirement	Report the date of the subscriber's retirement in YYYYMMDD format.	Required when ME060 = R	95.0%	834/2000/DTP/286/D8/03
66	ME066	COBRA Status Indicator	Integer	1	Indicator - COBRA usage	Use this field to report whether or not the member was covered using COBRA benefits. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
67	ME067	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
68	ME068	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
69	ME069	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
70	ME070	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
71	ME071	Pool Grouping Code	Look-up Table - Integer	1	Pool grouping code	Report the value that defines an employee attribute. The only valid codes for this field are: 1 = State Employee - Active 2 = State Employee - Retired 3 = Federal Employee - Active 4 = Federal Employee - Retired 5 = Municipal Employee - Active 6 = Municipal Employee - Retired	Required when ME134 = 3	100.0%	Administrative
72	ME072	Family Size	Integer	2	Family size as contracted	Report the number of individuals covered under the policy/contract identified in the subscriber's Plan-Specific Contract Number field (ME009).	All	100.0%	Administrative
73	ME073	Fully Insured Member Indicator	Look-up Table - Integer	1	Fully insured identifier	Use this field to report whether or not the member was fully insured. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
74	ME074	Interpreter Indicator	Look-up Table - Integer	1	Indicator - Interpreter need	Use this field to report whether or not the member requires the assistance of an interpreter. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
75	ME075	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
76	ME076	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
77	ME077	NAIC Code	External Code Source NAICS - Text	6	Member's standard NAICS code	Report the North American Industry Classification System (NAICS) code that describes the industry of the subscriber and/or member.	All	25.0%	Administrative
78	ME078	Employer ZIP Code	Text	9	ZIP code of the employer	Use this field to report the ZIP code associated with the subscriber's employer. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	Required when ME060 = A or P	98.0%	834/2100D/N4/ /03
79	ME079	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
80	ME080	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
81	ME081	Medicare Coverage Type Code	Integer	1	Medicare plan code	Report the value that defines if and what type of Medicare coverage applied to this line of eligibility. The only valid codes for this field are: 1 = Part A Only 2 = Part B Only 3 = Part A and B 4 = Part C Only 5 = Part C & D 6 = Part D Only 9 = Not Applicable 0 = No Medicare Coverage	Required when ME003 = 16, MA, MB, or MD	100.0%	
82	ME082	Employer Name	Text	60	Member's employer name	Report the name of the subscriber's/member's employer at the time of enrollment.	Required when ME060 = A or P	98.0%	834/2100D/NM1/36/03
83	ME083	Employer EIN	Text	9	Member's employer EIN	Report the federal tax ID number of the employer here. Do not use a hyphen or alpha prefix.	Required when ME060 = A or P	98.0%	834/2100D/NM1/24/09
84	ME101	Subscriber Last Name	Text	60	Last name of subscriber	Report the last name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as 'OBRIEN'; Carlton-Smythe should be reported as 'CARLTONSMYTHE'.	All	100.0%	271/2100C/NM1/ /03
85	ME102	Subscriber First Name	Text	25	First name of subscriber	Report the first name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as 'ANNEMARIE'.	All	100.0%	271/2100C/NM1/ /04
86	ME103	Subscriber Middle Initial	Text	1	Middle initial of subscriber	Report the subscriber's middle initial here.	All	2.0%	271/2100C/NM1/ / 05

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
87	ME104	Member Last Name	Text	60	Last name of member	Report the last name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as 'OBRIEN'; Carlton-Smythe should be reported as 'CARLTONSMYTHE'.	All	100.0%	271/2100C/NM1/ /03, 271/2100D/NM1/ /03
88	ME105	Member First Name	Text	25	First name of member	Report the first name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as 'ANNEMARIE'.	All	100.0%	271/2100C/NM1/ /04, 271/2100D/NM1/ /04
89	ME106	Member Middle Initial	Text	1	Middle initial of member	Report the middle initial of the member when available.	All	2.0%	271/2100C/NM1/ /05, 271/2100D/NM1/ /05
90	ME107	Submitter-Specific Unique Member ID	Text	50	Member's unique ID	Report the identifier the carrier/submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	All	100.0%	Administrative
91	ME108	Subscriber City	Text	30	City name of the subscriber	Report the city name of the subscriber.	All	98.0%	271/2100C/N4/ /01
92	ME109	Subscriber State	External Code Source 2 - Text	2	State/province of the subscriber	Use this field to report the subscriber's state using the two-character abbreviation as defined by the U.S. Postal Service.	All	99.0%	271/2100C/N4/ /02, 271/2100D/N4/ /02
93	ME110	Subscriber ZIP Code	External Code Source 2 - Text	9	ZIP code of the subscriber	Use this field to report the ZIP code associated with the subscriber's residence. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	99.0%	271/2100C/N4/ /03, 271/2100D/N4/ /03
94	ME111	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
95	ME112	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
96	ME113	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
97	ME114	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
98	ME115	Dental Deductible Amount	Decimal,2	10	Maximum out-of-pocket amount of member's deductible applied to dental benefits	Report the maximum amount of the member's deductible that is applied to dental services before dental services are covered. Report '0' when there is no deductible for this benefit. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	Required when ME020 = 1	98.0%	Administrative
99	ME116	Vision Deductible Amount	Decimal,2	10	Maximum out-of-pocket amount of member's deductible applied to vision benefits	Report the maximum amount of the Subscriber's/member's deductible that is applied to vision services before vision services are covered. Report '0' when there is no deductible for this benefit. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	Required when ME118 = 1	98.0%	Administrative
100	ME117	Submitter-Specific Unique Subscriber ID	Text	50	Subscriber's unique ID	Report the identifier the carrier/submitter uses internally to uniquely identify the subscriber. Used to create Unique Member ID and link across carrier's/submitter's files for reporting and aggregation.	All	100.0%	Administrative
101	ME118	Vision Benefit Indicator	Look-up Table - Integer	1	Indicator - Vision option	Use this field to report whether or not the member's plan included vision coverage. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
102	ME119	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
103	ME120	Actuarial Value	Text	6	Actuarial value	Report the actuarial value for the member's coverage for the time period indicated by enrollment start and end dates in 0.0000 format. For this field, please report the decimal.	All	100.0%	Administrative
104	ME121	Exchange Metallic Tier Code	Look-up Table - Integer	1	Standardized plan level in metal reference	Report the metal level benefits that the member is associated with in this line of eligibility. The only valid codes for this field are: 1 = Bronze 2 = Silver 3 = Gold 4 = Platinum 5 = Catastrophic 0 = Unknown / Not Applicable	All	100.0%	Administrative
105	ME122	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
106	ME123	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
107	ME124	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
108	ME125	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
109	ME126	Risk-Adjustment Covered Plan (RACP)	Integer	1	Subscriber/member enrolled in a risk-adjustment plan	Use this field to report whether or not the subscriber was enrolled with a non-grandfathered individual or small group plan underwritten and filed in the state of Connecticut. Large group plans, self-insured plans, and plans underwritten and filed in states other than Connecticut are not subject to risk-adjustment algorithms. Report the status as of the 15th of the month. The only valid codes for this field are: 1 = Yes 2 = No	All	100.0%	Administrative
110	ME127	Billable Member Flag	Integer	1	Indicator - Billable member	Use this field to report whether or not the member was billable. The only valid codes for this field are: 1 = Yes 2 = No	All	100.0%	
111	ME128	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
112	ME129	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
113	ME130	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
114	ME131	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
115	ME132	Monthly Premium Amount	Decimal,2	10	Combined contribution of employer and subscriber	Report the total monthly premium at the subscriber level. Report '0' if no premium is charged. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	100.0%	
116	ME133	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
117	ME134	APCD ID Code	Look-up Table - Integer	1	Member enrollment type	Report the value that describes the subscriber's/member's enrollment into one of the predefined categories; aligns enrollment to appropriate validations and thresholds. The only valid codes for this field are: 1 = Fully -Insured Commercial Group Enrollee (FIG) 2 = Self-Insured Group Enrollee (SIG) 3 = State or Federal Employer Enrollee 4 = Individual - Non-Group Enrollee 5 = Supplemental Policy Enrollee 6 = Integrated Care Organization (ICO) 0 = Unknown / Not Applicable	All	100.0%	Administrative
118	ME899	Record Type	Text	2	File type identifier	This field must be coded 'ME' to indicate the submission of eligibility data. The value reported here must match across the following three fields: HD004, TR004, and ME899.	All	100.0%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
1	MC001	Submitter Code	Text	8	Submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match the value reported across all file types in the following fields: HD002, TR002, ME001, MC001, PC001, DC001, and PV001. Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter. Note, too, that the first two characters of the submitter code are used to indicate the client while the third character designates the type of submitter. For Connecticut's APCD collection, the only valid prefixes are: CTC = Commercial carrier CTG = Governmental agency CTT = Third-party administrator / pharmacy benefits manager	All	100.0%	Administrative
2	MC002	National Plan ID	Text	10	CMS National Plan Identification Number (Plan ID)	Report as null until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	All	0.0%	835/1000A/REF/NF/02, 835/1000A/N1/XV/04
3	MC003	Insurance Type / Product Code	Look-up Table - Text	2	Type / Product Identification Code	Report the code that defines the type of insurance under which this member's claim line was processed. The only valid codes for this field are: 9 = Self-pay 11 = Other Non-Federal Programs (use of this value requires disclosure to Onpoint prior to submission) 12 = Preferred Provider Organization (PPO) 13 = Point of Service (POS) 14 = Exclusive Provider Organization (EPO) 15 = Indemnity Insurance 16 = Health Maintenance Organization (HMO) Medicare Risk (Use to report Medicare Part C / Medicare Advantage Plans) 17 = Dental Maintenance Organization (DMO) 96 = Husky Health A 97 = Husky Health B 98 = Husky Health C 99 = Husky Health D AM = Automobile Medical CH = Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (now TRICARE) DS = Disability HM = Health Maintenance Organization LM = Liability Medical MA = Medicare Part A (use to report Medicare Fee for Service only) MB = Medicare Part B (use to report Medicare Fee for Service only) MC = Medicaid OF = Other Federal Program (use of this value requires disclosure to Onpoint prior to submission) TV = Title V VA = Veterans Affairs Plan WC = Workers' Compensation ZZ = Mutually Defined (use of this value requires disclosure to Onpoint prior to submission)	All	100.0%	837/2000B/SBR/ /09
4	MC004	Payer Claim Control Number	Text	35	Payer claim control identifier	Report the unique identifier within the payer's system that applies to the entire claim.	All	100.0%	835/2100/CLP/ /07
5	MC005	Line Counter	Integer	4	Incremental line counter	Report the line number for this service within the claim. Start with '1' (not '0') and increment by 1 for each additional line. Do not include alphas or special characters.	All	100.0%	837/2400/LX/ /01
6	MC005A	Version Number	Integer	4	Claim service line version number	Report the version number of this claim service line. The version number begins with '0' and is incremented by 1 for each subsequent version of that service line. Do not include alphas or special characters.	All	100.0%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
7	MC006	Insured Group or Policy Number	Text	30	Group/policy number	Use this field to report the group or policy number. Notes: The value reported for this field should be reported consistently in the Insured Group or Policy Number field across file types: ME006, MC006, PC006, and DC006. This is not the number that uniquely identifies the subscriber. If a policy is sold to an individual as a non-group policy, report with a value of 'IND'. This principle pertains to all claim types: commercial, Medicaid, and Medicare.	All	98.0%	837/2000B/SBR/ /03
8	MC007	Subscriber Social Security Number	Text	9	Subscriber's Social Security number	Report the subscriber's Social Security number. Do not code using hyphens. If not available, report as null. If this field is not populated, MC008 must be populated. Notes: The value reported for this field should be reported consistently in the Subscriber Social Security Number field across file types: ME008, MC007, PC007, and DC007. This field will not be passed into the analytic file.	All	75.0%	835/2100/NM1/34/09
9	MC008	Plan-Specific Contract Number	Text	30	Contract number	Report the plan-assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents. If this field is not populated, MC007 must be populated. Notes: The value reported for this field should be reported consistently in the Plan-Specific Contract Number across file types: ME009, MC008, PC008, and DC008.	All	98.0%	835/2100/NM1/MI/09
10	MC009	Member Sequence Number	Text	20	Member's contract sequence number	Report the unique number/identifier of the member within the contract.	All	98.0%	N/A
11	MC010	Member Social Security Number	Text	9	Member's Social Security number	Report the member's Social Security number. Do not code using hyphens. If not available, report as null. Notes: The value reported for this field should be reported consistently in the Member Social Security Number field across file types: ME011, MC010, PC010, DC010. This field will not be passed into the analytic file.	All	75.0%	835/2100/NM1/34/09
12	MC011	Member Relationship Code	Look-up Table - Text	2	Member to subscriber relationship code	Report the value that defines the member's relationship to the subscriber. The only valid codes for this field are: 1 = Spouse 4 = Grandfather or Grandmother 5 = Grandson or Granddaughter 7 = Nephew or Niece 10 = Foster Child 12 = Other Adult 15 = Ward 17 = Stepson or Stepdaughter 18 = Self 19 = Child 20 = Self / Employee 21 = Unknown 22 = Handicapped Dependent 23 = Sponsored Dependent 24 = Dependent of a Minor Dependent 29 = Significant Other 32 = Mother 33 = Father 34 = Other Adult 36 = Emancipated Minor 39 = Organ Donor 40 = Cadaver Donor 41 = Injured Plaintiff 43 = Child Where Insured Has No Financial Responsibility 53 = Life Partner 76 = Dependent	All	98.0%	837/2000B/SBR/ /02 837/2000C/PAT/ /01
13	MC012	Member Gender Code	Look-up Table - Text	1	Member's gender	Report the member's gender as reported on enrollment form in alpha format. The only valid codes for this field are: F = Female M = Male U = Unknown Notes: The value reported for this field should be reported consistently in the Member Gender Code field across file types: ME013, MC012, PC012, and DC012.	All	100.0%	837/2010BA/DMG/ /03, 837/2010CA/DMG/ /03

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
14	MC013	Member Date of Birth	Full Date - Integer	8	Member's date of birth	Use this field to report the date on which the member was born in YYYYMMDD format. Notes: The value reported for this field should be reported consistently in the Member Date of Birth field across file types: ME014, MC013, PC013, and DC013.	All	99.0%	837/2010BA/DMG/D8/02 837/2010CA/DMG/D8/02
15	MC014	Member City	Text	30	City of the member	Report the city name of the member.	All	99.0%	837/2010BA/N4/ /01 837/2010CA/N4/ /01
16	MC015	Member State	External Code Source 2 - Text	2	State/province of the member	Use this field to report the member's state using the two-character abbreviation as defined by the U.S. Postal Service.	All	99.9%	837/2010BA/N4/ /02 837/2010CA/N4/ /02
17	MC016	Member ZIP Code	External Code Source 2 - Text	9	ZIP code of the member	Use this field to report the ZIP code associated with the member's residence. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	99.9%	837/2010BA/N4/ /03 837/2010CA/N4/ /03
18	MC017	Paid Date	Full Date - Integer	8	Date service approved by payer	Report the date that the payer approved this claim line for payment in YYYYMMDD format. This element was designed to capture a date other than the Paid Date (MC089). If Date Service Approved and Paid Date are the same, then the date here should match Paid Date.	All	100.0%	835/Header Financial Information/BPR/ /16
19	MC018	Admission Date	Full Date - Integer	8	Inpatient admission date	Report the date of admit to a facility in YYYYMMDD format. Only applies to facility claims where the reported Type of Bill (MC036) indicates an inpatient setting.	Required when MC094 = 002 and MC036 starts with 11, 18, 21, 28, 41, 65, 66, or 86	98.0%	Institutional 837/2300/DTP/435/DT/03
20	MC019	Admission Hour	Text	4	Admission time	Report the Admit Time in HHMM Format. Only applies to facility claims where the reported Type of Bill (MC036) indicates an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as '00'. 4 A.M. would be reported as '0400'; 4 P.M. would be reported as '1600'.	Required when MC094 = 002 and MC036 starts with 11, 18, 21, 28, 41	5.0%	Institutional 837/2300/DTP/435/03
21	MC020	Admission Type Code	External Code Source - NUBC - Integer	1	Admission type code	Report Admit Type as it applies to facility claims where the reported Type of Bill (MC036) indicates an inpatient setting. This code indicates the type of admission into an inpatient setting. Also known as Admission Priority.	Required when MC094 = 002 and MC036 starts with 11, 18, 21, 28, 41, 65, 66, or 86	98.0%	Institutional 837/2300/CL1/ /01
22	MC021	Admission Source Code	External Code Source - NUBC - Text	1	Admission source code	Report the code that applies to facility claims where the reported Type of Bill (MC036) indicates an inpatient setting. This code indicates how the patient was referred into an inpatient setting at the facility.	Required when MC094 = 002 and MC036 starts with 11, 18, 21, 28, 41, 65, 66, or 86	98.0%	Institutional 837/2300/CL1/ /02
23	MC022	Discharge Hour	Text	4	Discharge time	Report the Discharge Time in HHMM Format. Only applies to facility claims where the reported Type of Bill (MC036) indicates an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as '00'. 4 A.M. would be reported as '0400'; 4 P.M. would be reported as '1600'.	Required when MC094 = 002, MC069 is populated, and MC036 starts with 11, 18, 21, 28, 41, 65, 66, or 86	5.0%	Institutional 837/2300/CL1/ /02
24	MC023	Discharge Status Code	External Code Source - NUBC - Text	2	Inpatient discharge status code	Report the appropriate Discharge Status Code of the patient as defined by External Code Source.	Required when MC094 = 002 and MC036 starts with11, 18, 21, 28, 41, 65, 66, or 86	98.0%	Institutional 837/2300/CL1/ /03
25	MC024	Submitter-Specific Rendering Provider ID	Text	30	Service provider identification number	Report the carrier- / submitter-assigned service provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must also be reported in the Provider File using the Submitter-Specific Provider ID field (PV002).	All	99.0%	835/2100/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/PC/09, 835/2100/NM1/MC/09, 835/2100/NM1/BS/09
26	MC025	Rendering Provider Tax ID	Text	9	Service provider's tax ID number	Report the Federal Tax ID of the Service Provider identified in MC024 here. Do not use hyphen or alpha prefix.	All	97.0%	835/2100/NM1/FI/09
27	MC026	Rendering Provider NPI	External Code Source - NPPES - Text	10	National Provider Identifier (NPI) of the rendering provider	Report the primary National Provider Identifier (NPI) of the Servicing Provider reported in MC024. This NPI should also be reported using the National Provider Identifier field (PV039) in the provider file.	All	99.0%	Institutional 837/2010AA/NMI/XX/09 Professional 837/2420A/NMI/XX/09, 837/2310B/NM1/XX/09
28	MC027	Rendering Provider Entity Type Qualifier	Look-up Table - Integer	1	Rendering provider entity identifier code	Report the value that defines the provider entity type. Only individuals should be identified with a 1. Facilities, professional groups, and clinic sites should all be identified with a 2. The only valid codes for this field are: 1 = Person 2 = Non-person entity	All	98.0%	Institutional 837/2010AA/NM1/85/02 Professional 837/2420A/NM1/82/02, 837/2310B/NM1/82/02
29	MC028	Rendering Provider First Name	Text	25	First name of the rendering provider	Report the individual's first name here. If provider is a facility or organization, report as null.	Required when MC027 = 1	92.0%	Professional 837/2420A/NM1/82/04, 837/2310B/NM1/82/04

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30	MC029	Rendering Provider Middle Name	Text	25	Middle name of the rendering provider	Report the individual's middle name here. If provider is a facility or organization, report as null.	Required when MC027 = 1	2.0%	Professional 837/2420A/NM1/82/05, 837/2310B/NM1/82/05
31	MC030	Rendering Provider Last Name or Organization Name	Text	60	Last name or organization name of the rendering provider	Report the name of the organization or the last name of the individual provider. MC027 determines if this is an organization or individual name reported here.	All	94.0%	Institutional 837/2010AA/NM1/85/2/03 Professional 837/2420A/NM1/82/03, 837/2310B/NM1/82/03
32	MC031	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
33	MC032	Rendering Provider Taxonomy Code	External Code Source - WPC - Text	10	Taxonomy code of the rendering provider	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of nurses, assistants and laboratory technicians, where applicable, as well as Physicians, Medical Groups, Facilities, etc.	All	98.0%	Institutional 837/2000A/PRV/PXC/03 Professional 837/2310B/PRV/PXC/03
34	MC033	Rendering Provider City	Text	30	City name of the rendering provider	Report the city name of provider - preferably practice location.	All	98.0%	Institutional 837/2010AA/N4//01 Professional 837/2420C/N4//01, 837/2310C/N4/ /01
35	MC034	Rendering Provider State	External Code Source - USPS - Text	2	State of the rendering provider	Report the state of the service provider using the two-character abbreviation as defined by the U.S. Postal Service.	All	98.0%	Institutional 837/2010AA/N4//02 Professional 837/2420C/N4//02, 837/2310C/N4/ /02
36	MC035	Rendering Provider ZIP Code	External Code Source - USPS - Text	9	ZIP code of the rendering provider	Use this field to report the ZIP code associated with the rendering provider's location. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	98.0%	Institutional 837/2010AA/N4//03 Professional 837/2420C/N4//03, 837/2310C/N4/ /03
37	MC036	Type of Bill Code	External Code Source - NUBC - Text	3	Type of bill	Report the three-digit value that defines the type of bill on an institutional claim.	Required when MC094 = 002	98.0%	Institutional 837/2300/CLM/ /05-1 and 837/2300/CLM/ /05-3
38	MC037	Place of Service Code	External Code Source - CMS - Text	2	Place of service code	Report the two-digit value that defines the Place of Service on professional claim.	Required when MC094 = 001	100.0%	Professional 837/2300/CLM/ /05-1
39	MC038	Claim Status Code	Look-up Table - Integer	2	Claim line status	Report the value that defines the payment status of this claim line. The only valid codes for this field are: 1 = Processed as primary 2 = Processed as secondary 3 = Processed as tertiary 4 = Denied 19 = Processed as primary, forwarded to additional payer(s) 20 = Processed as secondary, forwarded to additional payer(s) 21 = Processed as tertiary, forwarded to additional payer(s) 22 = Reversal of previous payment 23 = Not our claim, forwarded to additional payer(s) 25 = Predetermination pricing only - no payment	All	98.0%	835/2100/CLP/ /02
40	MC039	Admitting Diagnosis Code	External Code Source - ICD - Text	7	Admitting diagnosis code	Report the diagnostic code assigned by provider that supported admission into the inpatient setting. Notes: Do not include the decimal point when coding this field.	Required when MC094 = 002 and MC036 starts with 11, 18, 21, 28, 41, 65, 66, or 86	98.0%	Institutional 837/2300/HI/BJ/01-2, 837/2300/HI/ABJ/01-2
41	MC040	External Cause of Injury Diagnosis (1)	External Code Source - ICD - Text	7	ICD diagnostic external cause of injury code	Report the external cause of injury code for patient when appropriate to the claim. Do not include the decimal point when coding this field.	MC094 = 002	3.0%	Institutional 837/2300/HI/BN/01-2, 837/2300/HI/ABN/01-2
42	MC041	Principal Diagnosis Code	External Code Source - ICD - Text	7	ICD principal diagnosis code	Use this field to report the ICD diagnosis for the principal diagnosis. Do not include the decimal point when coding this field.	All	99.0%	837/2300/HI/BK/01-2, 837/2300/HI/ABK/01-2
43	MC042	Other Diagnosis (1)	External Code Source - ICD - Text	7	ICD secondary diagnosis code	Use this field to report the ICD diagnosis code for the first secondary diagnosis. Do not include the decimal point when coding this field.	All	70.0%	Institutional 837/2300/HI/BF/01-2, 837/2300/HI/ABF/01-2 Professional 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2
44	MC043	Other Diagnosis (2)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the second secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	All	24.0%	Institutional 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2 Professional 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2

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45	MC044	Other Diagnosis (3)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the third secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	All	13.0%	Institutional 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2 Professional 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2
46	MC045	Other Diagnosis (4)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the fourth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	All	7.0%	Institutional 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2 Professional 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2
47	MC046	Other Diagnosis (5)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the fifth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	All	4.0%	Institutional 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2 Professional 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2
48	MC047	Other Diagnosis (6)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the sixth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	All	3.0%	Institutional 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2 Professional 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2
49	MC048	Other Diagnosis (7)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the seventh secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	All	3.0%	Institutional 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2 Professional 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2
50	MC049	Other Diagnosis (8)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the eighth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	All	2.0%	Institutional 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2 Professional 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2
51	MC050	Other Diagnosis (9)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the ninth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	All	1.0%	Institutional 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2 Professional 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2
52	MC051	Other Diagnosis (10)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the tenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	All	1.0%	Institutional 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2 Professional 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2
53	MC052	Other Diagnosis (11)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the eleventh secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	All	1.0%	Institutional 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2 Professional 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2
54	MC053	Other Diagnosis (12)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twelfth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	1.0%	Institutional 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2
55	MC054	Revenue Code	External Code Source - NUBC - Text	4	Revenue code	Report the valid National Uniform Billing Committee Revenue Code here. Code using leading zeroes, left-justified, and four digits.	Required when MC094 = 002	98.0%	835/2110/SVC/NU/01-2 835/2110/SVC/ /04
56	MC055	Procedure Code	External Code Source - AMA - OR - Carrier-Defined Table - Text	10	HCPCS/CPT code	Report a valid Procedure code for the claim line as defined by MC130. If using carrier-defined codes, submitter must provide reference table of values.	All	98.0%	835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2
57	MC056	Procedure Modifier Code (1)	External Code Source - AMA - Text	2	HCPCS / CPT code modifier	Report a valid procedure modifier when a modifier clarifies/improves the reporting accuracy of the associated Procedure Code (MC055).	Required when MC055 is populated	20.0%	835/2110/SVC/HC/01-3
58	MC057	Procedure Modifier Code (2)	External Code Source - AMA - Text	2	HCPCS/CPT code modifier	Report a valid procedure modifier when a modifier clarifies/improves the reporting accuracy of the associated Procedure Code (MC055).	Required when MC055 is populated	3.0%	835/2110/SVC/HC/01-4

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
59	MC058	Principal ICD Procedure Code	External Code Source - ICD - Text	7	ICD primary procedure code	Report the primary ICD CM/PCS procedure code when appropriate. Repeat this code on all lines of the facility claim. Do not code the decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41. Optional for other facility claims.	50.0%	Institutional 837/2300/HI/BR/01-2 837/2300/HI/BBR/01-2
60	MC059	Date of Service (From)	Full Date - Integer	8	Date of service (from)	Report the first date of service for the claim line in YYYYMMDD format.	All	98.0%	835/2110/DTM/472/02, 835/2110/DTM/150/02
61	MC060	Date of Service (Through)	Full Date - Integer	8	Date of Service (to)	Report the last service date for the claim line in YYYYMMDD format. For inpatient claims, the room and board line may or may not be equal to the discharge date. Procedures delivered during a visit should indicate which date they occurred.	All	98.0%	835/2110/DTM/472/02, 835/2110/DTM/151/02
62	MC061	Quantity	Decimal	15,2	Claim line units of service	Use this field to report the total units of measure for the individual type of service being performed. The unit of measure should be based on the relevant reporting code (e.g., CPT, revenue code, HCPCS). For example: • Anesthesiology = Minutes • Ambulance = Miles • Room and board = Days Notes: When coding this field, always report with two decimal places. If the actual value includes three decimal places, round to two. Do not include the decimal point when coding this field. If the value for this field is zero, report as '0', not as null. This field may be negative.	All	98.0%	835/2110/SVC/ /05
63	MC062	Charge Amount	Decimal	10,2	Amount of provider charges for the claim line	Report the charge amount for this claim line. 0 dollar charges allowed only when the procedure code indicates a Category II procedure code vs. a service code. When reporting Total Charges for facilities for the entire claim use 001 (the generally accepted Total Charge Revenue Code) in MC054 (Revenue Code). Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	99.0%	835/2110/SVC/ /02
64	MC063	Paid Amount	Decimal	10,2	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report '0' if line is paid as part of another procedure / claim line. Report '0' if the line is denied. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	99.0%	835/2110/SVC/ /03
65	MC064	Prepaid Amount	Decimal	10,2	Amount carrier has prepaid towards the claim line	Report the prepaid amount for the claim line. Report the Fee for Service equivalent amount for Capitated Services. Report '0' if there is no Prepaid Amount. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	99.0%	N/A
66	MC065	Copay Amount	Decimal	10,2	Amount of copay that the member is responsible to pay	Report the amount that defines a preset, fixed amount for this claim line service that the member is responsible to pay. Report '0' if no Copay applies. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	100.0%	835/2110/CAS/PR/3-03
67	MC066	Coinsurance Amount	Decimal	10,2	Amount of coinsurance that the member is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the member is responsible to pay. Report '0' if no Coinsurance applies. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	100.0%	835/2110/CAS/PR/2-03
68	MC067	Deductible Amount	Decimal	10,2	Amount of deductible that the member is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the member is responsible to pay. Report '0' if no Deductible applies to service. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	100.0%	835/2110/CAS/PR/1-03
69	MC068	Medical Record Number	Text	20	Patient control number	Report the provider-assigned encounter/visit number to identify patient treatment. This field is also known as the Patient Account Number.	Required when MC094 = 001 or 002	98.0%	837/2300/REF/EA/02
70	MC069	Discharge Date	Full Date - Integer	8	Discharge Date	Report the date on which the member was discharged from the facility in YYYYMMDD format. If member is still in-house and claim represents interim billing for interim payment, report the interim through date.	Required when MC094 = 002	98.0%	Institutional 837/2300/DTP/RD8/04 Professional 837/2300/DTP/D8/03,
71	MC070	Rendering Provider Country	External Code Source - ANSI - Text	3	Country name of the rendering provider	Report the three-character country code as defined by ISO 3166-1 alpha_3. Example: United States is reported as 'USA'	All	98.0%	N/A

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
72	MC071	DRG	External Code Source - CMS - Text	7	Diagnosis Related Group (DRG) code	Report the DRG number applied to this claim on every line to which its applicable. Insurers and health care claims processors shall code using the CMS methodology when available. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same element with the prefix of "A" and with a hyphen separating the AP DRG from the complexity level (e.g., AXXX-XX).	Required when MC094 = 002 and MC069 is populated and MC036 starts with 11,12, 18,41	98.0%	837/2300/HI/DR/01-2
73	MC072	DRG Version	External Code Source - CMS - Text	2	DRG version number	Report the version of the grouper used.	Required when MC071 is populated	20.0%	Administrative
74	MC073	APC	External Code Source - CMS - Text	4	Ambulatory Payment Classification (APC) number	Report the APC number applied to this claim line, with the leading zero(s) when applicable. Code using the CMS methodology.	Required when MC094 = 002 and MC036 starts with 13 or 14	20.0%	835/2110/REF/APC/02
75	MC074	APC Version	External Code Source - CMS - Text	2	APC version number	Report the version of the grouper used.	Required when MC073 is populated	20.0%	Administrative
76	MC075	National Drug Code (NDC)	External Code Source - FDA - Text	11	National Drug Code (NDC)	Report the NDC code used only when a medication is paid for as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code (MC055), and have a procedure code type of 'HCPCS'. Drug Code as defined by the FDA in 11 digit format (5-4-2) without hyphenation.	All	1.0%	837/2410/LIN/N4/03
77	MC076	Submitter-Specific Billing Provider ID	Text	30	Billing provider number	Report the carrier- / submitter-assigned billing provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must also be reported in the Provider File using the Submitter-Specific Provider ID field (PV002).	All	99.0%	837/2010BB/REF/G2/02
78	MC077	Billing Provider NPI	External Code Source - NPPES - Text	10	National Provider Identifier (NPI) of the billing provider	Report the primary National Provider Identifier (NPI) here. This NPI should also be reported using the National Provider Identifier field (PV039) in the provider file.	All	99.0%	837/2010AA/NM1/XX/09
79	MC078	Billing Provider Last Name or Organization Name	Text	60	Last name or organization name of billing provider	Report the name of the organization or last name of the individual provider. Individuals' names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes.	All	99.0%	837/2010AA/NM1/ /03
80	MC079	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
81	MC080	Payment Reason Code	External Code Source - HIPAA - OR - Carrier-Defined Table - Text	10	Payment reason code	Report the value that describes how the claim line was paid, either using a standard code set or a proprietary list pre-sent by submitter. If using carrier-defined codes, submitter must provide reference table of values.	Required when MC038 = 01, 02, 03, 19, 20, or 21	99.5%	835/2110/CAS
82	MC081	Capitated Encounter Indicator	Look-up Table - Integer	1	Indicator - Capitation payment	Use this field to report whether or not the service was covered under a capitated arrangement. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
83	MC082	Member Street Address (1)	Text	50	Street address of the member	Use this field to report the first line of the member's street address. Note that additional street address information can be reported using the Member Street Address 2 field (MC140).	All	90.0%	837/2010BA/N3/ /01 837/2010CA/N3/ /01
84	MC083	Other ICD Procedure Code (1)	External Code Source - ICD - Text	7	ICD secondary procedure code	Report the subsequent ICD CM procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code the decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41. Optional for other facility claims.	1.0%	Institutional 837/2300/HI/BQ/01-2 837/2300/HI/BBQ/01-2
85	MC084	Other ICD Procedure Code (2)	External Code Source - ICD - Text	7	ICD other procedure code	Report the third ICD procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code the decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41; optional for other facility claims	1.0%	Institutional 837/2300/HI/BQ/02-2 837/2300/HI/BBQ/02-2
86	MC085	Other ICD Procedure Code (3)	External Code Source - ICD - Text	7	ICD other procedure code	Report the fourth ICD procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code the decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41; optional for other facility claims	1.0%	Institutional 837/2300/HI/BQ/03-2 837/2300/HI/BBQ/03-2
87	MC086	Other ICD Procedure Code (4)	External Code Source - ICD - Text	7	ICD other procedure code	Report the fifth ICD procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code the decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41; optional for other facility claims	1.0%	Institutional 837/2300/HI/BQ/04-2 837/2300/HI/BBQ/04-2

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
88	MC087	Other ICD Procedure Code (5)	External Code Source - ICD - Text	7	ICD other procedure code	Report the sixth ICD procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code the decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41; optional for other facility claims	1.0%	Institutional 837/2300/HI/BQ/05-2 837/2300/HI/BBQ/05-2
89	MC088	Other ICD Procedure Code (6)	External Code Source - ICD - Text	7	ICD other procedure code	Report the seventh ICD procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code the decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41; optional for other facility claims	1.0%	Institutional 837/2300/HI/BQ/06-2 837/2300/HI/BBQ/06-2
90	MC089	Paid Date	Integer	8	Paid date of the claim line	Report the date that appears on the check and/or remittance and/or explanation of benefits and corresponds to any and all types of payment in YYYYMMDD format. This can be the same date as Processed Date. Notes: Claims paid in full, partial, or zero paid must have a date reported here.	All	100.0%	835/Header Financial Information/BPR/ /16
91	MC090	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
92	MC091	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
93	MC092	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
94	MC093	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
95	MC094	Type of Claim Code	Look-up Table - Text	3	Type of claim code	Report the value that defines the type of claim submitted for payment. The only valid codes for this field are: 001 = Professional 002 = Facility 003 = Reimbursement Form	All	100.0%	Administrative
96	MC095	Secondary Carrier Due Amount	Decimal	10,2	Amount due from a secondary carrier	Report the amount for which another payer is liable after the submitting payer has processed this claim line. Report '0' if there is no coordination of benefits (COB) / third-party liability (TPL) amount. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	Required when MC038 = 19, 20, or 21	98.0%	835/2110/CAS
97	MC096	Other Insurance Paid Amount	Decimal	10,2	Amount already paid by primary carrier	Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is secondary to the prior payer. Only report '0' if the prior payer paid 0 toward this claim line; otherwise, report as null. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	Required when MC038 = 2, 3, 20, or 21	98.0%	835/2110/CAS
98	MC097	Medicare Paid Amount	Decimal	10,2	Any amount Medicare paid towards claim line	Report the amount that Medicare paid toward this claim line. Only report '0' if Medicare paid 0 toward this claim line; otherwise do not report any value here. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	Required when MC115 = 1	100.0%	835/2110/CAS
99	MC098	Allowed Amount	Decimal	10,2	Allowed amount	Report the maximum amount contractually allowed and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often is less than or equal to the fee charged by the provider. Report '0' when the claim line is denied. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	99.0%	835/2110/CAS
100	MC099	Non-Covered Charge Amount	Decimal	10,2	Amount of claim line charge not covered	Report the amount that was charged on a claim line that was not reimbursable due to eligibility limitations or unmet provider requirements. Report '0' when the claim line was paid or fell into other categories. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	100.0%	835/2110/CAS
101	MC100	Carve-Out Vendor APCD ID	Text	8	Onpoint-defined and maintained code for linking across submitters	Report the Onpoint-assigned submitter code of the carve-out/parent vendor. This field identifies either the payer on behalf of whom the carve-out vendor is reporting (i.e., the parent) or the carve-out vendor contracted to report this claim. Contact the CT APCD for the appropriate value. If no vendor is affiliated with this claim line, report the code from MC001.	All	98.0%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
102	MC101	Subscriber Last Name	Text	60	Last name of subscriber	Report the last name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as 'OBRIEN'; Carlton-Smythe should be reported as 'CARLTONSMYTHE'.	All	100.0%	837/2010BA/NM1/ /03
103	MC102	Subscriber First Name	Text	25	First name of subscriber	Report the first name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as 'ANNEMARIE'.	All	100.0%	837/2010BA/NM1/ /04
104	MC103	Subscriber Middle Initial	Text	1	Middle initial of subscriber	Report the subscriber's middle initial.	All	2.0%	837/2010BA/NM1/ /05
105	MC104	Member Last Name	Text	60	Last name of member	Report the last name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as 'OBRIEN'; Carlton-Smythe should be reported as 'CARLTONSMYTHE'.	All	100.0%	837/2010CA/NM1/ /03, 837/2010BA/NM1/ /03
106	MC105	Member First Name	Text	25	First name of member	Report the first name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as 'ANNEMARIE'.	All	100.0%	837/2010CA/NM1/ /04, 837/2010BA/NM1/ /04
107	MC106	Member Middle Initial	Text	1	Middle initial of member	Report the middle initial of the member when available.	All	2.0%	837/2010CA/NM1/ /05, 837/2010BA/NM1/ /05
108	MC107	ICD Version Indicator	Look-up Table - Integer	1	International Classification of Diseases (ICD) version	Use this field to report whether the diagnoses on the claim were coded using ICD-9 or ICD-10 codes. The only valid codes for this field are: 9 = ICD-9 0 = ICD-10	Required when MC094 = 001 or 002 and MC041 is populated	100.0%	N/A
109	MC108	Procedure Modifier Code (3)	External Code Source - AMA - Text	2	HCPCS/CPT code modifier	Report a valid procedure modifier when a modifier clarifies/improves the reporting accuracy of the associated Procedure Code (MC055).	Required when MC055 is populated	0.0%	835/2110/SVC/HC/01-5
110	MC109	Procedure Modifier Code (4)	External Code Source - AMA - Text	2	HCPCS/CPT code modifier	Report a valid procedure modifier when a modifier clarifies/improves the reporting accuracy of the associated Procedure Code (MC055).	Required when MC055 is populated	0.0%	835/2110/SVC/HC/01-6
111	MC110	Claim Processed Date	Full Date - Integer	8	Claim processed date	Report the date the claim was processed by the carrier/submitter in YYYYMMDD format. This date can be equal to Paid or Denial Date, but cannot be after Paid or Denial Date.	All	98.0%	Administrative
112	MC111	Diagnosis Pointer	Integer	4	Diagnostic pointer number	Report the placement number of the diagnosis(-ses) to which a reported procedure is related for a professional claim. Can report up to four diagnostic positions within the first nine diagnoses that can be reported. Do not separate multiple mappings with spaces, zeros or special characters. Do not zero fill. EXAMPLE: Procedure related to diagnoses 1, 4, and 5 = '145'.	Required when MC094 = 001	98.0%	Professional 837/2400/SV1//07
113	MC112	Submitter-Specific Referring Provider ID	Text	30	Referring provider ID	Report the identifier of the provider that submitted the referral for the service or ordered the test that is on the claim (if applicable). The value in this field must also be reported in the Provider File using the Submitter-Specific Provider ID field (PV002).	Required when MC118 = 1	98.0%	Institutional 837/2310F/REF/G2/02
114	MC113	Payment Arrangement Indicator	Look-up Table - Integer	1	Payment arrangement type value	Report the value that defines the contracted payment methodology for this claim line. The only valid codes for this field are: 1 = Capitation 2 = Fee for Service 3 = Percent of Charges 4 = DRG 5 = Pay for Performance 6 = Global Payment 7 = Other 8 = Bundled Payment	All	98.0%	Administrative
115	MC114	Excluded Expenses Amount	Decimal	10,2	Amount not covered at the claim line due to benefit/plan limitation	Report the amount that the member has incurred towards covered but over-utilized services. Scenario: Physical Therapy units that are authorized for 15 visits at $50 a visit but utilized 20. The amount reported here would be 25000 to state over-utilization by $250.00. Report '0' if there are no Excluded Expenses. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	98.0%	Administrative
116	MC115	Medicare Payment Indicator	Look-up Table - Integer	1	Indicator - Medicare payment applied	Use this field to report whether or not Medicare paid for part or all of the services. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
117	MC116	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	all	0.0%	N/A
118	MC117	Authorization Needed Indicator	Look-up Table - Integer	1	Indicator - Authorization needed	Use this field to report whether or not the service required a pre-authorization. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
119	MC118	Referral Indicator	Look-up Table - Integer	1	Indicator - Referral needed	Use this field to report whether or not the service was preceded by a referral. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
120	MC119	Rendering Provider PCP Designation	Look-up Table - Integer	1	Indicator - PCP rendered service	Use this field to report whether or not the service was performed by the member's PCP. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
121	MC120	DRG Severity Level Code	External Code Source - CMS - Integer	1	Diagnosis Related Group (DRG) code severity level	Report the level used for severity adjustment when applicable.	Required when MC071 is populated	80.0%	Administrative
122	MC121	Member Responsibility Amount	Decimal	10,2	Total amount member must pay for this claim line	Report the total amount that the member is responsible to pay to the provider as part of their costs for services. Report '0' if there are no Out of Pocket expenses. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. This should total copay, coinsurance, and deductible amounts.	All	100.0%	Administrative
123	MC122	Global Payment Indicator	Look-up Table - Integer	1	Indicator - Global payment	Use this field to report whether or not the claim line was paid under a global payment arrangement. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
124	MC123	Denied Claim Indicator	Look-up Table - Integer	1	Denied claim line indicator	Use this field to report whether or not the claim line was denied. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
125	MC124	Denial Reason	External Code Source - HIPAA - OR - Carrier-Defined Table - Text	15	Denial reason code	Please report the code that defines the reason for the denial of the claim line using the externally maintained ASC X12 Claim Adjustment Reason Codes (CARCs), which can be found using the following URL: https://x12.org/codes/claim-adjustment-reason-codes Notes: If unable to report X12 CARCs, please continue to report using carrier-defined codes. If taking this approach, the submitter must provide Onpoint with a reference table of all non-standard values to support validation and use prior to submission.	Required when MC123 = 1	99.9%	835/2110/CAS
126	MC125	Submitter-Specific Attending Provider ID	Text	30	Attending provider ID	Report the ID that reflects the provider that provided general oversight of the member's care. This individual may or may not be the Servicing or Rendering provider. This value must also be reported in the Provider File using the Submitter-Specific Provider ID field (PV002). This field may or may not be the NPI based on the carrier's identifier system.	Required when MC094 = 002 and MC039 is populated	98.0%	Institutional 837/2310A/REF/G2/02

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
127	MC126	Accident Indicator	Look-up Table - Integer	1	Indicator - Accident related	Use this field to report whether or not the claim line was accident related. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
128	MC127	Family Planning Indicator	Look-up Table - Integer	1	Indicator - Family planning related	Use this field to report whether or not this claim was for services related to family planning. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Required when MC094 = 001	100.0%	Administrative
129	MC128	Employment-Related Indicator	Look-up Table - Integer	1	Indicator - Employment related	Use this field to report whether or not the rendered service was for an employment-related claim. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Required when MC094 = 001	100.0%	Administrative
130	MC129	EPSDT Code	Look-up Table - Integer	1	Indicator - EPSDT	Use this field to report whether or not the service was related to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits and the type of EPSDT service. The only valid codes for this field are: 1 = EPSDT Screening 2 = EPSDT Treatment 3 = EPSDT Referral 0 = Unknown / Not Applicable	Required when MC094 = 001	100.0%	Administrative
131	MC130	Procedure Code Type	Look-up Table - Integer	1	Claim line procedure code type identifier	Use this field to report the type of reported Procedure Code (MC055). The only valid codes for this field are: 1 = CPT, HCPCS Level 1, or HIPPS code 2 = HCPCS Level II Code 3 = HCPCS Level III Code (State Medicare code). 4 = American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) 5 = State-defined Procedure Code 6 = CPT Category II or CPT Category III code 7 = Custom Code - Submitter must provide a look-up table of values for MC055	Required when MC055 is populated	100.0%	Administrative
132	MC131	In-/Out-of-Network Indicator	Look-up Table - Integer	1	Indicator – In-network rate applied	Use this field to report whether or not the claim line was paid at an in-network rate. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
133	MC132	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
134	MC133	Bill Frequency Code	External Code Source - NUBC - Text	1	Bill frequency code	Report the valid frequency code of the claim to indicate version, credit/debit activity, and/or setting of claim. This should match the third digit in the Type of Bill reported in MC036. Default value for professional claims is '1'.	Required when MC094 = 001 or 002	100.0%	837/2300/CLM/ /05-3
135	MC134	Submitter-Specific Rendering Provider ID (2)	Text	30	Plan rendering number	Report the unique code that identifies for the carrier/submitter who or which individual provider cared for the member for the claim line in question. This code must be able to link to the Provider File. Any value in this field must also be reported in the Provider File using the Submitter-Specific Provider ID field (PV002).	All	99.0%	835/2100/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/PC/09, 835/2100/NM1/MC/09, 835/2100/NM1/BS/09
136	MC135	Provider Location Code	Text	30	Location of provider	Report the unique code that identifies the location/site. Any value in this field must also be reported in the Provider File using the Submitter-Specific Provider ID field (PV002).	All	90.0%	Administrative
137	MC136	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
138	MC137	Submitter-Specific Unique Member ID	Text	50	Member's unique ID	Report the identifier that the carrier/submitter uses internally to uniquely identify the member.	All	100.0%	Administrative
139	MC138	Claim Line Type	Look-up Table - Text	1	Claim line activity type code	Report the code that defines the claim line status in terms of adjudication. The only valid codes for this field are: A = Amendment B = Back-Out O = Original R = Replacement V = Void	All	98.0%	Administrative
140	MC139	Former Claim Number	Text	35	Previous claim number	Report the Payer Claim Control Number (MC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own PC004. Use of the Former Claim Number field to version claims can only be used if approved by Connecticut.	All	0.0%	Administrative
141	MC140	Member Street Address (2)	Text	50	Secondary street address of the member	Use this field to report the second line of the member's street address, which may include apartment number, suite identifier, or other secondary information.	All	2.0%	837/2010BA/N3/ /02 837/2010CA/N3/ /02
142	MC141	Submitter-Specific Unique Subscriber ID	Text	50	Subscriber's unique ID	Report the identifier that the carrier/submitter uses internally to uniquely identify the subscriber.	All	100.0%	Administrative
143	MC142	Other Diagnosis (13)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the thirteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/13-2, 837/2300/HI/ABF/13-2
144	MC143	Other Diagnosis (14)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the fourteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/14-2, 837/2300/HI/ABF/14-2
145	MC144	Other Diagnosis (15)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the fifteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/15-2, 837/2300/HI/ABF/15-2
146	MC145	Other Diagnosis (16)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the sixteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/16-2, 837/2300/HI/ABF/16-2
147	MC146	Other Diagnosis (17)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the seventeenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/17-2, 837/2300/HI/ABF/17-2
148	MC147	Other Diagnosis (18)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the eighteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/18-2, 837/2300/HI/ABF/18-2
149	MC148	Other Diagnosis (19)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the nineteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/19-2, 837/2300/HI/ABF/19-2
150	MC149	Other Diagnosis (20)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twentieth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/20-2, 837/2300/HI/ABF/20-2
151	MC150	Other Diagnosis (21)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twenty-first secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/21-2, 837/2300/HI/ABF/21-2
152	MC151	Other Diagnosis (22)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twenty-second secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/22-2, 837/2300/HI/ABF/22-2
153	MC152	Other Diagnosis (23)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twenty-third secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/23-2, 837/2300/HI/ABF/23-2
154	MC153	Other Diagnosis (24)	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twenty-fourth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094 = 002	0.0%	Institutional 837/2300/HI/BF/24-2, 837/2300/HI/ABF/24-2
155	MC154	Present on Admission - Principal Diagnosis	External Code Source - CMS - Text	1	POA code for Principal Diagnosis	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC041 is populated	95.0%	Institutional 837/2300/HI/BK/01-9 837/2300/HI/ABK/01-9
156	MC155	Present on Admission - Other Diagnosis (1)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 1	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC042 is populated	90.0%	Institutional 837/2300/HI/BF/01-9 837/2300/HI/ABF/01-9

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
157	MC156	Present on Admission - Other Diagnosis (2)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 2	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC043 is populated	90.0%	Institutional 837/2300/HI/BF/02-9 837/2300/HI/ABF/02-9
158	MC157	Present on Admission - Other Diagnosis (3)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 3	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC044 is populated	90.0%	Institutional 837/2300/HI/BF/03-9 837/2300/HI/ABF/03-9
159	MC158	Present on Admission - Other Diagnosis (4)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 4	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC045 is populated	90.0%	Institutional 837/2300/HI/BF/04-9 837/2300/HI/ABF/04-9
160	MC159	Present on Admission - Other Diagnosis (5)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 5	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC046 is populated	90.0%	Institutional 837/2300/HI/BF/05-9 837/2300/HI/ABF/05-9
161	MC160	Present on Admission - Other Diagnosis (6)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 6	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC047 is populated	90.0%	Institutional 837/2300/HI/BF/06-9 837/2300/HI/ABF/06-9
162	MC161	Present on Admission - Other Diagnosis (7)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 7	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC048 is populated	90.0%	Institutional 837/2300/HI/BF/07-9 837/2300/HI/ABF/07-9
163	MC162	Present on Admission - Other Diagnosis (8)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 8	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC049 is populated	90.0%	Institutional 837/2300/HI/BF/08-9 837/2300/HI/ABF/08-9
164	MC163	Present on Admission - Other Diagnosis (9)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 9	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC050 is populated	90.0%	Institutional 837/2300/HI/BF/09-9 837/2300/HI/ABF/09-9
165	MC164	Present on Admission - Other Diagnosis (10)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 10	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC051 is populated	90.0%	Institutional 837/2300/HI/BF/10-9 837/2300/HI/ABF/10-9

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
166	MC165	Present on Admission - Other Diagnosis (11)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 11	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC052 is populated	90.0%	Institutional 837/2300/HI/BF/11-9 837/2300/HI/ABF/11-9
167	MC166	Present on Admission - Other Diagnosis (12)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 12	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC053 is populated	90.0%	Institutional 837/2300/HI/BF/12-9 837/2300/HI/ABF/12-9
168	MC167	Present on Admission - Other Diagnosis (13)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 13	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC142 is populated	90.0%	Institutional 837/2300/HI/BF/13-9 837/2300/HI/ABF/13-9
169	MC168	Present on Admission - Other Diagnosis (14)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 14	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC143 is populated	90.0%	Institutional 837/2300/HI/BF/14-9 837/2300/HI/ABF/14-9
170	MC169	Present on Admission - Other Diagnosis (15)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 15	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC144 is populated	90.0%	Institutional 837/2300/HI/BF/15-9 837/2300/HI/ABF/15-9
171	MC170	Present on Admission - Other Diagnosis (16)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 16	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC145 is populated	90.0%	Institutional 837/2300/HI/BF/16-9 837/2300/HI/ABF/16-9
172	MC171	Present on Admission - Other Diagnosis (17)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 17	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC146 is populated	90.0%	Institutional 837/2300/HI/BF/17-9 837/2300/HI/ABF/17-9
173	MC172	Present on Admission - Other Diagnosis (18)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 18	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC147 is populated	90.0%	Institutional 837/2300/HI/BF/18-9 837/2300/HI/ABF/18-9
174	MC173	Present on Admission - Other Diagnosis (19)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 19	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC148 is populated	90.0%	Institutional 837/2300/HI/BF/19-9 837/2300/HI/ABF/19-9

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
175	MC174	Present on Admission - Other Diagnosis (20)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 20	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC149 is populated	90.0%	Institutional 837/2300/HI/BF/20-9 837/2300/HI/ABF/20-9
176	MC175	Present on Admission - Other Diagnosis (21)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 21	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC150 is populated	90.0%	Institutional 837/2300/HI/BF/21-9 837/2300/HI/ABF/21-9
177	MC176	Present on Admission - Other Diagnosis (22)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 22	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC151 is populated	90.0%	Institutional 837/2300/HI/BF/22-9 837/2300/HI/ABF/22-9
178	MC177	Present on Admission - Other Diagnosis (23)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 23	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC152 is populated	90.0%	Institutional 837/2300/HI/BF/23-9 837/2300/HI/ABF/23-9
179	MC178	Present on Admission - Other Diagnosis (24)	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 24	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as '1' (Exempt from POA Reporting); do not code as null. Notes: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC153 is populated	90.0%	Institutional 837/2300/HI/BF/24-9 837/2300/HI/ABF/24-9
180	MC179	Condition Code (1)	External Code Source - NUBC - Text	2	Condition code 1	Report the appropriate value that defines a condition for the claim or the patient. If not applicable, report as null.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BG/01-02
181	MC180	Condition Code (2)	External Code Source - NUBC - Text	2	Condition code 2	Report the appropriate value that defines a condition for the claim or the patient. If not applicable, report as null.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BG/02-02
182	MC181	Condition Code (3)	External Code Source - NUBC - Text	2	Condition code 3	Report the appropriate value that defines a condition for the claim or the patient. If not applicable, report as null.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BG/03-02
183	MC182	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
184	MC183	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
185	MC184	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
186	MC185	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
187	MC186	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
188	MC187	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
189	MC188	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
190	MC189	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
191	MC190	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
192	MC191	Value Code (1)	External Code Source - NUBC - Text	2	Value code 1	Report the appropriate value that defines a value category for the claim or the patient. If not applicable, do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BE/01-2

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
193	MC192	Value Amount (1)	Decimal	10,2	Amount that corresponds to Value Code - 1	Report the appropriate amount that corresponds to the value code. Only code '0' when 0 is an applicable amount for the Value Code Set. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	Required when MC191 is populated	100.0%	Institutional 837/2300/HI/BE/01-5
194	MC193	Value Code (2)	External Code Source - NUBC - Text	2	Value code 2	Report the appropriate value that defines a value category for the claim or the patient. If not applicable, do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BE/02-2
195	MC194	Value Amount (2)	Decimal	10,2	Amount that corresponds to Value Code - 2	Report the appropriate amount that corresponds to the value code. Only code '0' when 0 is an applicable amount for the Value Code Set. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	Required when MC193 is populated	100.0%	Institutional 837/2300/HI/BE/02-5
196	MC195	Value Code (3)	External Code Source - NUBC - Text	2	Value code 3	Report the appropriate value that defines a value category for the claim or the patient. If not applicable, do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BE/03-2
197	MC196	Value Amount (3)	Decimal	10,2	Amount that corresponds to Value Code - 3	Report the appropriate amount that corresponds to the value code. Only code '0' when 0 is an applicable amount for the Value Code Set. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	Required when MC195 is populated	100.0%	Institutional 837/2300/HI/BE/03-5
198	MC197	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
199	MC198	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
200	MC199	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
201	MC200	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
202	MC201	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
203	MC202	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
204	MC203	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
205	MC204	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
206	MC205	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
207	MC206	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
208	MC207	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
209	MC208	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
210	MC209	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
211	MC210	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
212	MC211	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
213	MC212	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
214	MC213	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
215	MC214	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
216	MC215	Occurrence Code (1)	External Code Source - NUBC - Text	2	Occurrence code 1	Report the appropriate value that defines an occurrence category for the claim or the patient. If not applicable, do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BH/01-2
217	MC216	Occurrence Date (1)	Integer	8	Date that corresponds to Occurrence Code - 1	Report the appropriate date that corresponds to the occurrence code in YYYYMMDD format.	Required when MC215 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/01-4
218	MC217	Occurrence Code (2)	External Code Source - NUBC - Text	2	Occurrence code 2	Report the appropriate value that defines an occurrence category for the claim or the patient. If not applicable, do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BH/02-2
219	MC218	Occurrence Date (2)	Integer	8	Date that corresponds to Occurrence Code - 2	Report the appropriate date that corresponds to the occurrence code in YYYYMMDD format.	Required when MC217 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/02-4
220	MC219	Occurrence Code (3)	External Code Source - NUBC - Text	2	Occurrence code 3	Report the appropriate value that defines an occurrence category for the claim or the patient. If not applicable, do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BH/03-2
221	MC220	Occurrence Date (3)	Integer	8	Date that corresponds to Occurrence Code - 3	Report the appropriate date that corresponds to the occurrence code in YYYYMMDD format.	Required when MC219 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/03-4

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
222	MC221	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
223	MC222	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
224	MC223	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
225	MC224	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
226	MC225	Occurrence Span Code (1)	External Code Source - NUBC - Text	2	Occurrence span code 1	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable, do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BI/01-2
227	MC226	Occurrence Span Start Date (1)	Integer	8	Start date that corresponds to Occurrence Span Code - 1	Report the appropriate start date that corresponds to the occurrence code in YYYYMMDD format.	Required when MC225 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/01-4
228	MC227	Occurrence Span End Date (1)	Integer	8	End date that corresponds to Occurrence Span Code - 1	Report the appropriate end date that corresponds to the occurrence code in YYYYMMDD format.	Required when MC226 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/01-4
229	MC228	Occurrence Span Code (2)	External Code Source - NUBC - Text	2	Occurrence span code 2	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable, do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BI/02-2
230	MC229	Occurrence Span Start Date (2)	Integer	8	Start date that corresponds to Occurrence Span Code - 2	Report the appropriate start date that corresponds to the occurrence code in YYYYMMDD format.	Required when MC228 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/02-4
231	MC230	Occurrence Span End Date (2)	Integer	8	End date that corresponds to Occurrence Span Code - 2	Report the appropriate end date that corresponds to the occurrence code in YYYYMMDD format.	Required when MC229 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/02-4
232	MC231	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
233	MC232	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
234	MC233	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
235	MC234	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
236	MC235	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
237	MC236	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
238	MC237	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
239	MC238	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
240	MC239	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
241	MC240	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
242	MC241	APCD ID Code	Look-up Table - Integer	1	Member enrollment type	Report the value that describes the member's/subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate validations and thresholds. The only valid codes for this field are: 1 = Fully- Insured Commercial Group Enrollee (FIG) 2 = Self-Insured Group Enrollee (SIG) 3 = State or Federal Employer Enrollee 4 = Individual - Non-Group Enrollee 5 = Supplemental Policy Enrollee 6 = Integrated Care Organization (ICO) 0 = Unknown / Not Applicable	All	100.0%	Administrative
243	MC899	Record Type	Text	2	File type identifier	This field must be coded 'MC' to indicate the submission of medical claims data. The value reported here must match across the following three fields: HD004, TR004, and MC899.	All	100.0%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
1	PC001	Submitter Code	Text	8	Submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match the value reported across all file types in the following fields: HD002, TR002, ME001, MC001, PC001, DC001, and PV001. Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter. Note, too, that the first two characters of the submitter code are used to indicate the client while the third character designates the type of submitter. For Connecticut's APCD collection, the only valid prefixes are: CTC = Commercial carrier CTG = Governmental agency CTT = Third-party administrator / pharmacy benefits manager	All	100.0%
2	PC002	National Plan ID	Text	10	CMS National Plan Identification Number (Plan ID)	Do not report any value here until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	All	0.0%
3	PC003	Insurance Type / Product Code	Look-up Table - Text	2	Type/product identification code	Report the code that defines the type of insurance under which this member's claim line was processed. The only valid codes for this field are: 9 = Self-pay 11 = Other Non-Federal Programs (use of this value requires disclosure to Onpoint prior to submission) 12 = Preferred Provider Organization (PPO) 13 = Point of Service (POS) 14 = Exclusive Provider Organization (EPO) 15 = Indemnity Insurance 16 = Health Maintenance Organization (HMO) Medicare Risk (use to report Medicare Part C/Medicare Advantage Plans) 17 = Dental Maintenance Organization (DMO) 96 = Husky Health A 97 = Husky Health B 98 = Husky Health C 99 = Husky Health D AM = Automobile Medical CH = Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (now TRICARE) DS = Disability HM = Health Maintenance Organization LM = Liability Medical MA = Medicare Part A (Medicare Fee for Service only) MB = Medicare Part B (Medicare Fee for Service only) MC = Medicaid MD = Medicare Part D OF = Other Federal Program (use of this value requires disclosure to Onpoint prior to submission) TV = Title V VA = Veterans Affairs Plan WC = Workers' Compensation ZZ = Mutually Defined (use of this value requires disclosure to Onpoint prior to	All	100.0%
4	PC004	Payer Claim Control Number	Text	35	Payer claim control identification	Report the unique identifier within the payer's system that applies to the entire claim.	All	100.0%
5	PC005	Line Counter	Text	4	Incremental line counter	Report the line number for this service within the claim. Start with '1' (not '0') and increment by 1 for each additional line. Do not include alphas or special characters.	All	100.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
6	PC005A	Version Number	Text	4	Claim service line version number	Report the version number of this claim service line. The version number begins with '0' and is incremented by 1 for each subsequent version of that service line. Do not include alphas or special characters.	All	100.0%
7	PC006	Insured Group or Policy Number	Text	30	Group/policy number	Use this field to report the group or policy number. Notes: The value reported for this field should be reported consistently in the Insured Group or Policy Number field across file types: ME006, MC006, PC006, and DC006. This is not the number that uniquely identifies the subscriber. If a policy is sold to an individual as a non-group policy, report with a value of 'IND'. This principle pertains to all claim types: commercial, Medicaid, and Medicare.	All	98.0%
8	PC007	Subscriber Social Security Number	Text	9	Subscriber's Social Security number	Report the subscriber's Social Security number. Do not code using hyphens. If not available, do not report any value here. If this field is not populated, PC008 must be populated. Notes: The value reported for this field should be reported consistently in the Subscriber Social Security Number field across file types: ME008, MC007, PC007, and DC007. This field will not be passed into the analytic file.	All	75.0%
9	PC008	Plan-Specific Contract Number	Text	30	Contract number	Report the plan-assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents. If this field is not populated, PC007 must be populated. Notes: The value reported for this field should be reported consistently in the Plan-Specific Contract Number across file types: ME009, MC008, PC008, and DC008.	All	98.0%
10	PC009	Member Sequence Number	Text	20	Member's contract sequence number	Report the unique number/identifier of the member within the contract.	All	98.0%
11	PC010	Member Social Security Number	Text	9	Member's Social Security number	Report the member's Social Security number. Do not code using hyphens. If not available, report as null. Notes: The value reported for this field should be reported consistently in the Member Social Security Number field across file types: ME011, MC010, PC010, DC010. This field will not be passed into the analytic file.	All	75.0%
12	PC011	Member Relationship Code	Look-up Table - Text	2	Member to subscriber relationship code	Report the value that defines the member's relationship to the subscriber. The only valid codes for this field are: 1 = Spouse 4 = Grandfather or Grandmother 5 = Grandson or Granddaughter 7 = Nephew or Niece 10 = Foster Child 12 = Other Adult 15 = Ward 17 = Stepson or Stepdaughter 18 = Self 19 = Child 20 = Self / Employee 21 = Unknown 22 = Handicapped Dependent 23 = Sponsored Dependent 24 = Dependent of a Minor Dependent 29 = Significant Other 32 = Mother 33 = Father 34 = Other Adult 36 = Emancipated Minor 39 = Organ Donor 40 = Cadaver Donor 41 = Injured Plaintiff 43 = Child Where Insured Has No Financial Responsibility 53 = Life Partner 76 = Dependent	All	98.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
13	PC012	Member Gender Code	Look-up Table - Text	1	Member's gender	Report the member's gender as reported on enrollment form in alpha format. The only valid codes for this field are: F = Female M = Male U = Unknown Notes: The value reported for this field should be reported consistently in the Member Gender Code field across file types: ME013, MC012, PC012, and DC012.	All	100.0%
14	PC013	Member Date of Birth	Full Date - Integer	8	Member's date of birth	Use this field to report the date on which the member was born in YYYYMMDD format. Notes: The value reported for this field should be reported consistently in the Member Date of Birth field across file types: ME014, MC013, PC013, and DC013.	All	99.0%
15	PC014	Member City	Text	50	City of the member	Report the city name of the member.	All	99.0%
16	PC015	Member State	External Code Source - USPS - Text	2	State/province of the member	Use this field to report the member's state using the two-character abbreviation as defined by the U.S. Postal Service.	All	99.9%
17	PC016	Member ZIP Code	External Code Source - USPS - Text	9	ZIP code of the member	Use this field to report the ZIP code associated with the member's residence. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	99.9%
18	PC017	Paid Date	Full Date - Integer	8	Date service approved by payer	Report the date that the payer approved this claim line for payment in YYYYMMDD format. This element was designed to capture a date other than the Paid Date (PC063). If Date Service Approved and Paid Date are the same, then the date here should match Paid Date.	All	100.0%
19	PC018	Submitter-Specific Pharmacy ID	Text	30	Pharmacy number	Report either the NCPDP or NABP number of the dispensing pharmacy.	All	98.0%
20	PC019	Pharmacy Tax ID	Text	9	Pharmacy tax ID number	Report the federal tax ID number of the pharmacy. Do not use hyphens or alpha prefix.	All	20.0%
21	PC020	Pharmacy Name	Text	100	Name of pharmacy	Report the name of the pharmacy.	All	90.0%
22	PC021	Pharmacy NPI	External Code Source - NPPES - text	10	National Provider Identifier (NPI) of the pharmacy	Report the pharmacy's primary National Provider Identifier (NPI). This NPI should also be reported using the National Provider Identifier field (PV039) in the provider file.	All	99.0%
23	PC022	Pharmacy City	Text	30	City name of the pharmacy	Report the city name of the dispensing pharmacy (preferably pharmacy location).	All	85.0%
24	PC023	Pharmacy State	External Code Source - USPS - Text	2	State of the pharmacy	Report the state where the dispensing pharmacy is located.	All	90.0%
25	PC024	Pharmacy ZIP Code	External Code Source - USPS - Text	9	ZIP code of the pharmacy	Use this field to report the ZIP code associated with the pharmacy's location. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	90.0%
26	PC024A	Pharmacy Country	External Code Source - ANSI - Text	3	Country code of the pharmacy	Report the three-character country code as defined by ISO 3166-1 alpha_3.	All	90.0%
27	PC025	Claim Status Code	Look-up Table - integer	2	Claim line status	Report the value that defines the payment status of this claim line. The only valid codes for this field are: 1 = Processed as primary 2 = Processed as secondary 3 = Processed as tertiary 4 = Denied 19 = Processed as primary, forwarded to additional payer(s) 20 = Processed as secondary, forwarded to additional payer(s) 21 = Processed as tertiary, forwarded to additional payer(s) 22 = Reversal of previous payment 23 = Not our claim, forwarded to additional payer(s) 25 = Predetermination Pricing Only - no payment	All	98.0%
28	PC026	National Drug Code (NDC)	External Code Source - FDA - Text	11	National Drug Code (NDC)	Report the NDC as defined by the FDA in 11-digit format (5-4-2) without hyphenation.	All	98.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
29	PC027	Drug Name	External Code Source - FDA - Text	80	Name of the drug as supplied	Report the name of the drug that aligns to the National Drug Code. Do not report generic names with brand NDC.	All	95.0%
30	PC028	New Prescription or Refill	Text	2	Prescription status indicator	Use this field to report whether this is a new prescription or refill. The only valid codes for this field are: 00 = New prescription 01–99 = Number of refill(s)	All	99.0%
31	PC029	Generic Drug Indicator	Look-up Table - Integer	1	Generic drug indicator	Use this field to report whether or not the dispensed drug was a generic drug. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%
32	PC030	Dispense as Written Code	Look-up Table - Integer	1	Prescription dispensing activity code	Report the value that defines how the drug was dispensed. The only valid codes for this field are: 1 = Physician dispense as written 2 = Member dispense as written 3 = Pharmacy dispense as written 4 = No generic available 5 = Brand dispensed as generic 6 = Override 7 = Substitution not allowed, brand drug mandated by law 8 = Substitution allowed, generic drug not available in marketplace 9 = Other	All	98.0%
33	PC031	Compound Drug Indicator	Look-up Table - Integer	1	Compound drug indicator	Use this field to indicate whether or not the dispensed drug was a compound drug. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	0.0%
34	PC032	Date Prescription Filled	Full Date - Integer	8	Prescription filled date	Report the date on which the pharmacy filled and dispensed the prescription to the member in YYYYMMDD format.	All	99.0%
35	PC033	Quantity	Decimal	10,2	Claim line units dispensed	Report the number of total units dispensed.	All	75.0%
36	PC034	Days' Supply	Integer	4	Prescription supply days	Report the number of days that the prescription will last if taken as prescribed.	All	10.0%
37	PC035	Charge Amount	Decimal	10,2	Amount of provider charges for the claim line	Report the amount that the provider / dispensing facility billed the insurance carrier for this claim line service. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	99.0%
38	PC036	Paid Amount	Decimal	10,2	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report '0' if line is paid as part of another procedure / claim line. Report as 0 if the line is denied. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	99.0%
39	PC037	Ingredient Cost / List Price	Decimal	10,2	Amount defined as the list price or ingredient cost	Report the amount that defines this pharmaceutical cost/price. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	99.0%
40	PC038	Postage Amount Claimed	Decimal	10,2	Amount of postage claimed on the claim line	Report the amount of postage claimed for this claim line. Report '0' if postage does not apply Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	100.0%
41	PC039	Dispensing Fee	Decimal	10,2	Amount of dispensing fee for the claim line	Report the amount that defines the dispensing fee. Report '0' if fee does not apply. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	99.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
42	PC040	Copay Amount	Decimal	10,2	Amount of copay member is responsible to pay	Report the amount that is the member's responsibility. Report '0' if no copay applies. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	100.0%
43	PC041	Coinsurance Amount	Decimal	10,2	Amount of coinsurance member is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the member is responsible to pay. Report '0' if no coinsurance applies. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	100.0%
44	PC042	Deductible Amount	Decimal	10,2	Amount of deductible member is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the member is responsible to pay. Report '0' if no deductible applies to service. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	100.0%
45	PC043	Submitter-Specific Prescribing Provider ID	Text	30	Prescribing provider identification	Report the identification of the prescribing provider here. The information in this element must also be reported in the Provider File using the Submitter-Specific Provider ID field (PV002).	All	99.0%
46	PC044	Prescribing Provider First Name	Text	25	First name of prescribing physician	Report the first name of the prescribing physician.	All	50.0%
47	PC045	Prescribing Provider Middle Name	Text	25	Middle name of prescribing physician	Report the middle name of the prescribing physician.	All	2.0%
48	PC046	Prescribing Provider Last Name	Text	60	Last name of prescribing physician	Report the last name of the prescribing physician.	All	50.0%
49	PC047	Prescribing Provider DEA Number	Text	9	Prescriber DEA number	Report the primary DEA number for the prescribing physician.	All	80.0%
50	PC048	Prescribing Provider NPI	External Code Source - NPPES - Text	10	National Provider Identifier (NPI) of the prescribing physician	Report the primary National Provider Identifier (NPI) of the prescribing physician identified in PC043–PC047. This NPI should also be reported using the National Provider Identifier field (PV039) in the provider file when the provider is contracted with the carrier.	All	99.0%
51	PC049	Prescribing Provider Plan Number	Text	30	Carrier-assigned provider plan ID	Report the prescribing physician's plan number here. Do not report any value here if contracted with the carrier. This identifier must match an identifier reported in the Provider File.	All	100.0%
52	PC050	Prescribing Provider State License Number	Text	30	Prescribing physician license number	Report the state license number for the provider identified in the Plan Provider ID field (PV002) in the Provider File. For a doctor, this is the medical license number; for a non-doctor, this is the practice license number. Do not use zero-fill. If not available or not applicable, such as for a group or corporate entity, report as null.	All	50.0%
53	PC051	Prescribing Provider Street Address (1)	Text	50	Street address of the prescribing physician	Use this field to report the first line of the prescribing physician's street address.	All	10.0%
54	PC052	Prescribing Provider Street Address (2)	Text	50	Secondary street address of the prescribing physician	Use this field to report the second line of the prescribing physician's street address, which may include office number, suite identifier, P.O. Box, or other secondary information.	All	10.0%
55	PC053	Prescribing Provider City	Text	30	City of the prescribing physician	Use this field to report the prescribing physician's city.	All	10.0%
56	PC054	Prescribing Provider State	External Code Source - USPS - Text	2	State of the prescribing physician	Use this field to report the prescribing physician's state using the two-character abbreviation as defined by the U.S. Postal Service.	All	10.0%
57	PC055	Prescribing Provider ZIP Code	External Code Source - USPS - Text	9	ZIP code of the prescribing physician	Use this field to report the ZIP code associated with the prescribing physician's location. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	10.0%
58	PC056	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
59	PC057	Mail-Order Pharmacy Indicator	Look-up Table - Integer	1	Indicator – Mail-order option	Use this field to report whether or not the pharmacy was a mail-order pharmacy. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%
60	PC058	Script Number	Text	20	Prescription number	Report the unique identifier of the prescription.	All	99.9%
61	PC059	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
62	PC060	Single/Multiple Source Indicator	Look-up Table - Integer	1	Indicator - Drug source	Report the value that defines the availability of the pharmaceutical. The only valid codes for this field are: 1 = Multi-source brand 2 = Multi-source brand with generic equivalent 3 = Single-source brand 4 = Single-source brand with generic equivalent 5 = Unknown	All	100.0%
63	PC061	Member Street Address (1)	Text	50	Street address of the member	Use this field to report the first line of the member's street address. Note that additional street address information can be reported using the Member Street Address 2 field (PC109).	All	90.0%
64	PC062	Billing Provider Tax ID	Text	9	Billing provider's federal tax ID number (FTIN)	Report the federal tax ID number of the billing provider. Do not use hyphens or alpha prefix.	All	90.0%
65	PC063	Payment Date / Settlement Date	Integer	8	Paid date of the claim line	Report the date that appears on the check and/or remittance and/or explanation of benefits and corresponds to any and all types of payment in YYYYMMDD format. This can be the same date as Processed Date. Notes: Claims paid in full, partial, or zero paid must have a date reported here.	Required when PC025 = 01, 02, 03, 19, 20, or 21	100.0%
66	PC064	Date Prescription Written	Full Date - Integer	8	Date prescription was prescribed	Report the date that was written on the prescription or called in by the prescribing physician's office in YYYYMMDD format.	All	98.0%
67	PC065	Secondary Carrier Due Amount	Decimal	10,2	Amount due from a secondary carrier	Report the amount for which another payer is liable after the submitting payer has processed this claim line. Report '0' if there is no coordination of benefits (COB) / third-party liability (TPL) amount. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	Required when PC025 = 19, 20, or 21	98.0%
68	PC066	Other Insurance Paid Amount	Decimal	10,2	Amount already paid by primary carrier	Report the amount that a prior payer has paid for this claim line, which indicates that the submitting payer is "secondary" to the prior payer. Only report '0' if the prior payer paid 0 toward this claim line; otherwise do not report any value here. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	Required when PC025 = 2, 3, 20, or 21	98.0%
69	PC067	Medicare Paid Amount	Decimal	10,2	Any amount Medicare paid towards claim line	Report the amount that Medicare paid toward this claim line. Only report '0' if Medicare paid 0 toward this claim line; otherwise do not report any value here. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	Required when PC112 = 1	100.0%
70	PC068	Allowed Amount	Decimal	10,2	Allowed amount	Report the maximum amount contractually allowed and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often is less than or equal to the fee charged by the pharmacy. Report '0' when the claim line is denied. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	99.0%
71	PC069	Member Responsibility Amount	Decimal	10,2	Amount member paid out of pocket on the claim line	Report the amount that the member has paid beyond the copay structure. Report '0' if the member has not paid toward this claim line. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	20.0%
72	PC070	Rebate Indicator	Look-up Table - Integer	1	Indicator - Rebate	Use this field to report whether or not the prescribed drug was eligible for rebate. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%
73	PC071	State Sales Tax Amount	Decimal	10,2	Amount of applicable sales tax on the claim line	Report the amount of state sales tax applied to this claim line. Report '0' if state sales tax does not apply. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'.	All	0.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
74	PC072	Carve-Out Vendor APCD ID	Text	8	Onpoint-defined and maintained code for linking across submitters	Report the Onpoint-assigned submitter code of the carve-out/parent vendor. This field identifies either the payer on behalf of whom the carve-out vendor is reporting (i.e., the parent) or the carve-out vendor contracted to report this claim. Contact the CT APCD for the appropriate value. If no vendor is affiliated with this claim line, report the code from PC001.	All	98.0%
75	PC073	Formulary Indicator	Look-up Table - Integer	1	Indicator - Formulary inclusion	Use this field to report whether or not the prescribed drug was on the carrier's formulary list. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%
76	PC074	Pharmaceutical Route of Administration	External Codes Source - NCPDP - Text	2	Route of administration	Report the pharmaceutical route of administration that defines the method of drug administration. Notes: Valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP standards set.	All	99.9%
77	PC075	Drug Unit of Measure	External Codes Source - NCPDP - Text	2	Units of measure	Report the code that defines the unit of measure for the drug dispensed. Notes: With the exception of the supplementary code of "OT" (Other), valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP's Billing Unit Standards set. The only valid codes for this field are: EA = Each GM = Grams ML = Milliliter OT = Other	All	80.0%
78	PC101	Subscriber Last Name	Text	60	Last name of subscriber	Report the last name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as 'OBRIEN'; Carlton-Smythe should be reported as 'CARLTONSMYTHE'.	All	100.0%
79	PC102	Subscriber First Name	Text	25	First name of subscriber	Report the first name of the subscriber here. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as 'ANNEMARIE'.	All	100.0%
80	PC103	Subscriber Middle Initial	Text	1	Middle initial of subscriber	Report the subscriber's middle initial.	All	2.0%
81	PC104	Member Last Name	Text	60	Last name of member	Report the last name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as 'OBRIEN'; Carlton-Smythe should be reported as 'CARLTONSMYTHE'.	All	100.0%
82	PC105	Member First Name	Text	25	First name of member	Report the first name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as 'ANNEMARIE'.	All	100.0%
83	PC106	Member Middle Initial	Text	1	Middle initial of member	Report the middle initial of the member when available.	All	2.0%
84	PC107	Submitter-Specific Unique Member ID	Text	50	Member's unique ID	Report the identifier that the carrier/submitter uses internally to uniquely identify the member.	All	100.0%
85	PC108	Submitter-Specific Unique Subscriber ID	Text	50	Subscriber's unique ID	Report the identifier the carrier/submitter uses internally to uniquely identify the subscriber.	All	100.0%
86	PC109	Member Street Address (2)	Text	50	Secondary street address of the member	Use this field to report the second line of the member's street address, which may include apartment number, suite identifier, or other secondary information.	All	2.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
87	PC110	Claim Line Type	Look-up Table - Text	1	Claim line activity type code	Report the code that defines the claim line status in terms of adjudication. The only valid codes for this field are: A = Amendment B = Back-Out O = Original R = Replacement V = Void	All	98.0%
88	PC111	Former Claim Number	Text	35	Previous claim number	Report the Payer Claim Control Number (PC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own PC004. Use of the Former Claim Number field to version claims can only be used if approved by Connecticut.	All	0.0%
89	PC112	Medicare Payment Indicator	Look-up Table - Integer	1	Indicator - Medicare payment applied	Use this field to report whether or not Medicare paid for part or all of the services. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%
90	PC113	Pregnancy Indicator	Look-up Table - Integer	1	Indicator - Pregnancy	Use this field to report whether or not the member was pregnant. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%
91	PC114	Principal Diagnosis Code	External Codes Source - ICD - Text	7	ICD diagnosis code	Report the ICD diagnosis code when applicable. Do not include the decimal point when coding this field.	All	1.0%
92	PC115	ICD Version Indicator	Look-up Table - Integer	1	International Classification of Diseases (ICD) version	Use this field to report whether the diagnoses on the claim were coded using ICD-9 or ICD-10 codes. The only valid codes for this field are: 9 = ICD-9 0 = ICD-10	Required when PC114 is populated	100.0%
93	PC116	Denied Claim Indicator	Look-up Table - Integer	1	Indicator - Denied claim line	Use this field to report whether or not the claim line was denied. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%
94	PC117	Denial Reason	External Code Source - HIPAA - OR - Carrier-Defined Table - Text	30	Denial reason code	Please report the code that defines the reason for the denial of the claim line using the externally maintained NCPDP code set for the "Reject Code" field (511-FB). Notes: If unable to report the NCPDP code set, please continue to report using carrier-defined codes. If taking this approach, the submitter must provide Onpoint with a reference table of all non-standard values to support validation and use prior to submission.	Required when PC116 = 1	100.0%
95	PC118	Payment Arrangement Indicator	Look-up Table - Integer	1	Payment arrangement type value	Use this field to report the value that defines the contracted payment methodology for this claim line. The only valid codes for this field are: 1 = Capitation 2 = Fee for Service 3 = Percent of Charges 4 = DRG 5 = Pay for Performance 6 = Global Payment 7 = Other 8 = Bundled Payment	All	98.0%
96	PC119	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
97	PC120	APCD ID Code	Look-up Table - Integer	1	Member enrollment type	Use this field to report the value that describes the member's/subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate validations and thresholds. The only valid codes for this field are: 1 = Fully Insured Commercial Group Enrollee (FIG) 2 = Self-Insured Group Enrollee (SIG) 3 = State or Federal Employer Enrollee 4 = Individual - Non-Group Enrollee 5 = Supplemental Policy Enrollee 6 = Integrated Care Organization (ICO) 0 = Unknown / Not Applicable	All	100.0%
98	PC899	Record Type	Text	2	File type Identifier	This field must be coded 'PC' to indicate the submission of pharmacy claims data. The value reported here must match across the following three fields: HD004, TR004, and PC899.	All	100.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
1	DC001	Submitter Code	Text	8	Submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match the value reported across all file types in the following fields: HD002, TR002, ME001, MC001, PC001, DC001, and PV001. Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter. Note, too, that the first two characters of the submitter code are used to indicate the client while the third character designates the type of submitter. For Connecticut's APCD collection, the only valid prefixes are: CTC = Commercial carrier CTG = Governmental agency CTT = Third-party administrator / pharmacy benefits manager	All	100.0%	Administrative
2	DC002	National Plan ID	Text	10	CMS National Plan Identification Number (Plan ID)	Report as null until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	All	0.0%	835/1000A/REF/NF/02, 835/1000A/N1/XV/04
3	DC003	Insurance Type / Product Code	Look-up Table - Text	2	Type / Product Identification Code	Use this field to report the code that defines the type of insurance under which this member's claim line was processed. The only valid codes for this field are: 9 = Self-pay 11 = Other Non-Federal Programs (use of this value requires disclosure to Onpoint prior to submission) 12 = Preferred Provider Organization (PPO) 13 = Point of Service (POS) 14 = Exclusive Provider Organization (EPO) 15 = Indemnity Insurance 16 = Health Maintenance Organization (HMO) Medicare Risk (Use to report Medicare Part C / Medicare Advantage Plans) 17 = Dental Maintenance Organization (DMO) 96 = Husky Health A 97 = Husky Health B 98 = Husky Health C 99 = Husky Health D AM = Automobile Medical CH = Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (now TRICARE) DS = Disability HM = Health Maintenance Organization LM = Liability Medical MA = Medicare Part A (use to report Medicare Fee for Service only) MB = Medicare Part B (use to report Medicare Fee for Service only) MC = Medicaid OF = Other Federal Program (use of this value requires disclosure to Onpoint prior to submission) TV = Title V VA = Veterans Affairs Plan WC = Workers' Compensation ZZ = Mutually Defined (use of this value requires disclosure to Onpoint prior to submission)	All	100.0%	837/2000B/SBR/ /09
4	DC004	Payer Claim Control Number	Text	35	Payer claim control identifier	Use this field to report the unique identifier within the payer's system that applies to the entire claim.	All	100.0%	835/2100/CLP/ /07
5	DC005	Line Counter	Integer	4	Incremental line counter	Use this field to report the line number for this service within the claim. Start with '1' (not '0') and increment by 1 for each additional line. Do not include alphas or special characters.	All	100.0%	837/2400/LX/ /01
6	DC005A	Version Number	Integer	4	Claim service line version number	Use this field to report the version number of this claim service line. The version number begins with '0' and is incremented by 1 for each subsequent version of that service line. Do not include alphas or special characters.	All	100.0%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
7	DC006	Insured Group or Policy Number	Text	30	Group/policy number	Use this field to report the group or policy number. Notes: The value reported for this field should be reported consistently in the Insured Group or Policy Number field across file types: ME006, MC006, PC006, and DC006. This is not the number that uniquely identifies the subscriber. If a policy is sold to an individual as a non-group policy, report with a value of 'IND'. This principle pertains to all claim types: commercial, Medicaid, and Medicare.	All	98.0%	837/2000B/SBR/ /03
8	DC007	Subscriber Social Security Number	Text	9	Subscriber's Social Security number	Use this field to report the subscriber's Social Security number. Do not code using hyphens. If not available, report as null. If this field is not populated, DC008 must be populated. Notes: The value reported for this field should be reported consistently in the Subscriber Social Security Number field across file types: ME008, MC007, PC007, and DC007. This field will not be passed into the analytic file.	All	75.0%	835/2100/NM1/34/09
9	DC008	Plan-Specific Contract Number	Text	30	Contract number	Use this field to report the plan-assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents. If this field is not populated, DC007 must be populated. Notes: The value reported for this field should be reported consistently in the Plan-Specific Contract Number across file types: ME009, MC008, PC008, and DC008.	All	98.0%	835/2100/NM1/MI/09
10	DC009	Member Sequence Number	Text	20	Member's contract sequence number	Use this field to report the unique number/identifier of the member within the contract.	All	98.0%	N/A
11	DC010	Member Social Security Number	Text	9	Member's Social Security number	Use this field to report the member's Social Security number. Do not code using hyphens. If not available, report as null. If not available, report as null. Notes: The value reported for this field should be reported consistently in the Member Social Security Number field across file types: ME011, MC010, PC010, DC010. This field will not be passed into the analytic file.	All	75.0%	835/2100/NM1/34/09
12	DC011	Member Relationship Code	Look-up Table - Text	2	Member to subscriber relationship code	Use this field to report the value that defines the member's relationship to the subscriber. The only valid codes for this field are: 1 = Spouse 4 = Grandfather or Grandmother 5 = Grandson or Granddaughter 7 = Nephew or Niece 10 = Foster Child 12 = Other Adult 15 = Ward 17 = Stepson or Stepdaughter 18 = Self 19 = Child 20 = Self / Employee 21 = Unknown 22 = Handicapped Dependent 23 = Sponsored Dependent 24 = Dependent of a Minor Dependent 29 = Significant Other 32 = Mother 33 = Father 34 = Other Adult 36 = Emancipated Minor 39 = Organ Donor 40 = Cadaver Donor 41 = Injured Plaintiff 43 = Child Where Insured Has No Financial Responsibility 53 = Life Partner 76 = Dependent	All	98.0%	837/2000B/SBR/ /02 837/2000C/PAT/ /01

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
13	DC012	Member Gender Code	Look-up Table - Text	1	Member's gender	Use this field to report the member's gender as reported on enrollment form in alpha format. The only valid codes for this field are: F = Female M = Male O = Other U = Unknown Notes: The value reported for this field should be reported consistently in the Member Gender field across file types: ME013, MC012, PC012, and DC012.	All	100.0%	837/2010BA/DMG/ /03, 837/2010CA/DMG/ /03
14	DC013	Member Date of Birth	Full Date - Integer	8	Member's date of birth	Use this field to report the date on which the member was born in YYYYMMDD format. Notes: The value reported for this field should be reported consistently in the Member Date of Birth field across file types: ME014, MC013, PC013, and DC013.	All	99.0%	837/2010BA/DMG/D8/02 837/2010CA/DMG/D8/02
15	DC014	Member City	Text	30	City of the member	Use this field to report the city name of the member.	All	99.0%	837/2010BA/N4/ /01 837/2010CA/N4/ /01
16	DC015	Member State	External Code Source 2 - Text	2	State/province of the member	Use this field to report the member's state using the two-character abbreviation as defined by the U.S. Postal Service.	All	99.9%	837/2010BA/N4/ /02 837/2010CA/N4/ /02
17	DC016	Member ZIP Code	External Code Source 2 - Text	9	ZIP code of the member	Use this field to report the ZIP code associated with the member's residence. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	99.9%	837/2010BA/N4/ /03 837/2010CA/N4/ /03
18	DC017	Paid Date	Full Date - Integer	8	Date service approved by payer	Use this field to report the date on which the payer approved this claim line for payment in YYYYMMDD format. This element was designed to capture a date other than the Paid Date (DC049). If Date Service Approved and Paid Date are the same, then the date here should match Paid Date.	All	100.0%	835/Header Financial Information/BPR/ /16
19	DC018	Submitter-Specific Rendering Provider ID	Text	30	Service provider identification number	Use this field to report the carrier- / submitter-assigned service provider number. This number should be the identifier used for internal identification purposes and should not routinely change. The value in this field also must be reported in the Provider File using the Submitter-Specific Provider ID field (PV002).	All	99.0%	835/2100/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/PC/09, 835/2100/NM1/MC/09, 835/2100/NM1/BS/09
20	DC019	Rendering Provider Tax ID	Text	9	Service provider's tax ID number	Use this field to report the Federal Tax ID of the Service Provider identified in DC018 here. Do not use hyphen or alpha prefix.	All	97.0%	835/2100/NM1/FI/09
21	DC020	Rendering Provider NPI	External Code Source - NPPES - Text	10	National Provider Identifier (NPI) of the rendering provider	Use this field to report the primary National Provider Identifier (NPI) of the Servicing Provider reported in DC018. This NPI should also be reported using the National Provider Identifier field (PV039) in the provider file.	All	99.0%	837/2420A/NMI/XX/09, 837/2310B/NM1/XX/09
22	DC021	Rendering Provider Entity Type Qualifier	Look-up Table - Integer	1	Rendering provider entity identifier code	Use this field to report the value that defines the provider entity type. Only individuals should be reported using a value of '1'. Facilities, professional groups, and clinic sites should be reported using a value of '2'. The only valid codes for this field are: 1 = Person 2 = Non-person entity	All	98.0%	837/2420A/NM1/82/02, 837/2310B/NM1/82/02
23	DC022	Rendering Provider First Name	Text	25	First name of the rendering provider	Use this field to report the individual's first name here. If provider is a facility or organization, report as null.	Required when DC021 = 1	92.0%	837/2420A/NM1/82/04, 837/2310B/NM1/82/04
24	DC023	Rendering Provider Middle Name	Text	25	Middle name of the rendering provider	Use this field to report the individual's middle name here. If provider is a facility or organization, report as null.	Required when DC021= 1	2.0%	837/2420A/NM1/82/05, 837/2310B/NM1/82/05
25	DC024	Rendering Provider Last Name or Organization Name	Text	60	Last name or organization name of the rendering provider	Use this field to report the name of the organization or the last name of the individual provider.	All	94.0%	837/2420A/NM1/82/03, 837/2310B/NM1/82/03
26	DC025	In-/Out-of-Network Indicator	Look-up Table - Integer	1	Indicator – In-network rate applied	Use this field to report whether or not the claim line was paid at an in-network rate. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative

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27	DC026	Carve-Out Vendor APCD ID	Text	8	Onpoint-defined and maintained code for linking across submitters	Use this field to report the Onpoint-assigned submitter code of the carve-out/parent vendor. This field identifies either the payer on behalf of whom the carve-out vendor is reporting (i.e., the parent) or the carve-out vendor contracted to report this claim. Contact the CT APCD for the appropriate value. If no vendor is affiliated with this claim line, report the code from DC001.	All	98.0%	Administrative
28	DC027	Rendering Provider Taxonomy Code	External Code Source - WPC - Text	10	Taxonomy code of the rendering provider	Use this field to report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of nurses, assistants and laboratory technicians, where applicable, as well as Physicians, Medical Groups, Facilities, etc.	All	98.0%	837/2310B/PRV/PXC/03
29	DC028	Rendering Provider City	Text	30	City name of the rendering provider	Use this field to report the city name of provider - preferably practice location.	All	98.0%	837/2420C/N4//01, 837/2310C/N4/ /01
30	DC029	Rendering Provider State	External Code Source - USPS - Text	2	State of the rendering provider	Use this field to report the state of the service provider using the two-character abbreviation as defined by the U.S. Postal Service.	All	98.0%	837/2420C/N4//02, 837/2310C/N4/ /02
31	DC030	Rendering Provider ZIP Code	External Code Source - USPS - Text	9	ZIP code of the rendering provider	Use this field to report the ZIP code associated with the rendering provider's location. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	98.0%	837/2420C/N4//03, 837/2310C/N4/ /03
32	DC031	Place of Service Code	External Code Source - CMS - Text	2	Place of service code	Use this field to report the two-digit value that defines the Place of Service on professional claim.	All	100.0%	837/2300/CLM/ /05-1
33	DC033	Claim Status Code	Look-up Table - Integer	2	Claim line status	Use this field to report the value that defines the payment status of this claim line. The only valid codes for this field are: 1 = Processed as primary 2 = Processed as secondary 3 = Processed as tertiary 4 = Denied 19 = Processed as primary, forwarded to additional payer(s) 20 = Processed as secondary, forwarded to additional payer(s) 21 = Processed as tertiary, forwarded to additional payer(s) 22 = Reversal of previous payment 23 = Not our claim, forwarded to additional payer(s) 25 = Predetermination pricing only - no payment	All	98.0%	835/2100/CLP/ /02
34	DC033	Procedure Code/CDT Code	External Code Source - AMA - OR - Carrier-	10	HCPCS/CPT/CDT code	Use this field to report the CDT, HCPCS, or CPT code for the service rendered.	All	98.0%	835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2
35	DC034	Procedure Modifier (1)	External Code Source - AMA - Text	2	HCPCS / CPT code modifier	Use this field to report a valid procedure modifier when a modifier clarifies/improves the reporting accuracy of the associated Procedure Code (DC033).	All	20.0%	835/2110/SVC/HC/01-3
36	DC035	Procedure Modifier (2)	External Code Source - AMA - Text	2	HCPCS/CPT code modifier	Use this field to report a valid procedure modifier when a modifier clarifies/improves the reporting accuracy of the associated Procedure Code (DC033).	All	3.0%	835/2110/SVC/HC/01-4
37	DC036	Date of Service (From)	Full Date - Integer	8	Date of service (from)	Use this field to report the first date of service for the claim line in YYYYMMDD format.	All	98.0%	835/2110/DTM/472/02, 835/2110/DTM/150/02
38	DC037	Date of Service (Through)	Full Date - Integer	8	Date of Service (to)	Use this field to report the last service date for the claim line in YYYYMMDD format.	All	98.0%	835/2110/DTM/472/02, 835/2110/DTM/151/02
39	DC038	Charge Amount	Decimal	10,2	Amount of provider charges for the claim line	Use this field to report the charge amount for this claim line. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	99.0%	835/2110/SVC/ /02
40	DC039	Paid Amount	Decimal	10,2	Amount paid by the carrier for the claim line	Use this field to report the amount paid for the claim line. Report '0' if line is paid as part of another procedure / claim line. Report '0' if the line is denied. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	99.0%	835/2110/SVC/ /03
41	DC040	Copay Amount	Decimal	10,2	Amount of copay that the member is responsible to pay	Use this field to report the amount that defines a preset, fixed amount for this claim line service that the member is responsible to pay. Report '0' if no Copay applies. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	100.0%	835/2110/CAS/PR/3-03
42	DC041	Coinsurance Amount	Decimal	10,2	Amount of coinsurance that the member is responsible to pay	Use this field to report the amount that defines a calculated percentage amount for this claim line service that the member is responsible to pay. Report '0' if no Coinsurance applies. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	100.0%	835/2110/CAS/PR/2-03

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
43	DC042	Deductible Amount	Decimal	10,2	Amount of deductible that the member is responsible to pay on the claim line	Use this field to report the amount that defines a preset, fixed amount for this claim line service that the member is responsible to pay. Report '0' if no Deductible applies to service. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	100.0%	835/2110/CAS/PR/1-03
44	DC043	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
45	DC044	Member Street Address (1)	Text	50	Street address of the member	Use this field to report the first line of the member's street address. Note that additional street address information can be reported using the Member Street Address 2 field (DC089).	All	90.0%	837/2010BA/N3/ /01 837/2010CA/N3/ /01
46	DC045	Billing Provider Tax ID	Text	9	Billing provider's tax ID number	Use this field to report the Federal Tax ID of the Billing Provider. Do not use hyphen or alpha prefix.	All	99.0%	837/2010AA/REF/EI/02, 837/2010AA/REF/SY/02
47	DC046	Submitter-Specific Billing Provider ID	Text	30	Billing provider number	Use this field to report the carrier- / submitter-assigned ID number for the billing provider. This number should be the identifier used for internal identification purposes and should not routinely change. The value in this field also must be reported in the Provider File using the Submitter-Specific Provider ID field (PV002).	All	99.0%	837/2010BB/REF/G2/02
48	DC047	Billing Provider NPI	External Code Source - NPPES - Text	10	National Provider Identifier (NPI) of the billing provider	Use this field to report the billing provider's primary National Provider Identifier (NPI). This NPI also should be reported using the National Provider Identifier field (PV039) in the provider file.	All	99.0%	837/2010AA/NM1/XX/09
49	DC048	Billing Provider Last Name or Organization Name	Text	60	Last name or organization name of billing provider	Use this field to report the name of the organization or the last name of the individual billing provider. Individuals' names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes.	All	99.0%	837/2010AA/NM1/ /03
50	DC049	Paid Date	Integer	8	Paid date of the claim line	Use this field to report the date that appears on the check and/or remittance and/or explanation of benefits and corresponds to any and all types of payment in YYYYMMDD format. This can be the same date as Processed Date. Notes: Claims paid in full, partial, or zero paid must have a date reported here.	All	100.0%	835/Header Financial Information/BPR/ /16
51	DC050	Allowed Amount	Decimal	10,2	Allowed amount	Use this field to report the maximum amount contractually allowed and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often is less than or equal to the fee charged by the provider. Report '0' when the claim line is denied. Do not code the decimal or round up/down to whole dollars; code zero cents ('00') when applicable. EXAMPLE: 150.00 is reported as '15000'; 150.70 is reported as '15070'. May be reported as a negative.	All	99.0%	835/2110/CAS
52	DC051	Tooth Oral Cavity (Quadrant or Arch) (1)	Text	2	Tooth Oral Cavity (Quadrant or Arch) (1)	Use this field to report the standard quadrant identifier.	All	0.0%	837/2400/SV3/ /04-1
53	DC052	Tooth Oral Cavity (Quadrant or Arch) (2)	Text	2	Tooth Oral Cavity (Quadrant or Arch) (2)	Use this field to report the standard quadrant identifier.	All	0.0%	837/2400/SV3/ /04-2
54	DC053	Tooth Oral Cavity (Quadrant or Arch) (3)	Text	2	Tooth Oral Cavity (Quadrant or Arch) (3)	Use this field to report the standard quadrant identifier.	All	0.0%	837/2400/SV3/ /04-3
55	DC054	Tooth Oral Cavity (Quadrant or Arch) (4)	Text	2	Tooth Oral Cavity (Quadrant or Arch) (4)	Use this field to report the standard quadrant identifier.	All	0.0%	837/2400/SV3/ /04-4
56	DC055	Tooth Oral Cavity (Quadrant or Arch) (5)	Text	2	Tooth Oral Cavity (Quadrant or Arch) (5)	Use this field to report the standard quadrant identifier.	All	0.0%	837/2400/SV3/ /04-5
57	DC056	Tooth System Qualifier	Text	2	Tooth System Qualifier	Use this field to report the code list qualifier code that identifies the tooth designation system used in the claim. The only valid codes for this field are: JO = ANSI/ADA/ISO Specification No. 3950 JP = ADA Universal/National Tooth Designation System	All	99.9%	837/2400/TOO/ /01
58	DC057	Tooth (1) - Number or Letter	Text	2	Tooth (1) - Number or Letter	Use this field to report the first tooth number or letter associated with the claim.	All	10.0%	837/2400/TOO/ /02
59	DC058	Tooth (1) – Surface Code (1)	Text	1	Tooth (1) – Surface Code (1)	Use this field to report the first tooth surface (of a maximum of five) for the services rendered for Tooth (1).	All	0.0%	837/2400/TOO/ /03-1
60	DC059	Tooth (1) – Surface Code (2)	Text	1	Tooth (1) – Surface Code (2)	Use this field to report the second tooth surface (of a maximum of five) for the services rendered for Tooth (1).	All	0.0%	837/2400/TOO/ /03-2
61	DC060	Tooth (1) – Surface Code (3)	Text	1	Tooth (1) – Surface Code (3)	Use this field to report the third tooth surface (of a maximum of five) for the services rendered for Tooth (1).	All	0.0%	837/2400/TOO/ /03-3
62	DC061	Tooth (1) – Surface Code (4)	Text	1	Tooth (1) – Surface Code (4)	Use this field to report the fourth tooth surface (of a maximum of five) for the services rendered for Tooth (1).	All	0.0%	837/2400/TOO/ /03-4
63	DC062	Tooth (1) – Surface Code (5)	Text	1	Tooth (1) – Surface Code (5)	Use this field to report the fifth tooth surface (of a maximum of five) for the services rendered for Tooth (1).	All	0.0%	837/2400/TOO/ /03-5
64	DC063	Tooth (2) - Number or Letter	Text	2	Tooth (2) - Number or Letter	Use this field to report the second tooth number or letter associated with the claim.	All	0.0%	837/2400/TOO/ /02
65	DC064	Tooth (2) – Surface Code (1)	Text	1	Tooth (2) – Surface Code (1)	Use this field to report the first tooth surface (of a maximum of five) for the services rendered for Tooth (2).	All	0.0%	837/2400/TOO/ /03-1
66	DC065	Tooth (2) – Surface Code (2)	Text	1	Tooth (2) – Surface Code (2)	Use this field to report the second tooth surface (of a maximum of five) for the services rendered for Tooth (2).	All	0.0%	837/2400/TOO/ /03-2

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
67	DC066	Tooth (2) – Surface Code (3)	Text	1	Tooth (2) – Surface Code (3)	Use this field to report the third tooth surface (of a maximum of five) for the services rendered for Tooth (2).	All	0.0%	837/2400/TOO/ /03-3
68	DC067	Tooth (2) – Surface Code (4)	Text	1	Tooth (2) – Surface Code (4)	Use this field to report the fourth tooth surface (of a maximum of five) for the services rendered for Tooth (2).	All	0.0%	837/2400/TOO/ /03-4
69	DC068	Tooth (2) – Surface Code (5)	Text	1	Tooth (2) – Surface Code (5)	Use this field to report the fifth tooth surface (of a maximum of five) for the services rendered for Tooth (2).	All	0.0%	837/2400/TOO/ /03-5
70	DC069	Tooth (3) - Number or Letter	Text	2	Tooth (3) - Number or Letter	Use this field to report the third tooth number or letter associated with the claim.	All	0.0%	837/2400/TOO/ /02
71	DC070	Tooth (3) – Surface Code (1)	Text	1	Tooth (3) – Surface Code (1)	Use this field to report the first tooth surface (of a maximum of five) for the services rendered for Tooth (3).	All	0.0%	837/2400/TOO/ /03-1
72	DC071	Tooth (3) – Surface Code (2)	Text	1	Tooth (3) – Surface Code (2)	Use this field to report the second tooth surface (of a maximum of five) for the services rendered for Tooth (3).	All	0.0%	837/2400/TOO/ /03-2
73	DC072	Tooth (3) – Surface Code (3)	Text	1	Tooth (3) – Surface Code (3)	Use this field to report the third tooth surface (of a maximum of five) for the services rendered for Tooth (3).	All	0.0%	837/2400/TOO/ /03-3
74	DC073	Tooth (3) – Surface Code (4)	Text	1	Tooth (3) – Surface Code (4)	Use this field to report the fourth tooth surface (of a maximum of five) for the services rendered for Tooth (3).	All	0.0%	837/2400/TOO/ /03-4
75	DC074	Tooth (3) – Surface Code (5)	Text	1	Tooth (3) – Surface Code (5)	Use this field to report the fifth tooth surface (of a maximum of five) for the services rendered for Tooth (3).	All	0.0%	837/2400/TOO/ /03-5
76	DC075	Tooth (4) - Number or Letter	Text	2	Tooth (4) - Number or Letter	Use this field to report the fourth tooth number or letter associated with the claim.	All	0.0%	837/2400/TOO/ /02
77	DC076	Tooth (4) – Surface Code (1)	Text	1	Tooth (4) – Surface Code (1)	Use this field to report the first tooth surface (of a maximum of five) for the services rendered for Tooth (4).	All	0.0%	837/2400/TOO/ /03-1
78	DC077	Tooth (4) – Surface Code (2)	Text	1	Tooth (4) – Surface Code (2)	Use this field to report the second tooth surface (of a maximum of five) for the services rendered for Tooth (4).	All	0.0%	837/2400/TOO/ /03-2
79	DC078	Tooth (4) – Surface Code (3)	Text	1	Tooth (4) – Surface Code (3)	Use this field to report the third tooth surface (of a maximum of five) for the services rendered for Tooth (4).	All	0.0%	837/2400/TOO/ /03-3
80	DC079	Tooth (4) – Surface Code (4)	Text	1	Tooth (4) – Surface Code (4)	Use this field to report the fourth tooth surface (of a maximum of five) for the services rendered for Tooth (4).	All	0.0%	837/2400/TOO/ /03-4
81	DC080	Tooth (4) – Surface Code (5)	Text	1	Tooth (4) – Surface Code (5)	Use this field to report the fifth tooth surface (of a maximum of five) for the services rendered for Tooth (4).	All	0.0%	837/2400/TOO/ /03-5
82	DC081	Subscriber Last Name	Text	60	Last name of subscriber	Use this field to report the last name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as 'OBRIEN'; Carlton-Smythe should be reported as 'CARLTONSMYTHE'.	All	100.0%	837/2010BA/NM1/ /03
83	DC082	Subscriber First Name	Text	25	First name of subscriber	Use this field to report the first name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as 'ANNEMARIE'.	All	100.0%	837/2010BA/NM1/ /04
84	DC083	Subscriber Middle Initial	Text	1	Middle initial of subscriber	Use this field to report the subscriber's middle initial.	All	2.0%	837/2010BA/NM1/ /05
85	DC084	Member Last Name	Text	60	Last name of member	Use this field to report the last name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as 'OBRIEN'; Carlton-Smythe should be reported as 'CARLTONSMYTHE'.	All	100.0%	837/2010CA/NM1/ /03, 837/2010BA/NM1/ /03
86	DC085	Member First Name	Text	25	First name of member	Use this field to report the first name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as 'ANNEMARIE'.	All	100.0%	837/2010CA/NM1/ /04, 837/2010BA/NM1/ /04
87	DC086	Member Middle Initial	Text	1	Middle initial of member	Use this field to report the middle initial of the member when available.	All	2.0%	837/2010CA/NM1/ /05, 837/2010BA/NM1/ /05
88	DC087	Submitter-Specific Unique Member ID	Text	50	Member's unique ID	Use this field to report the identifier that the carrier/submitter uses internally to uniquely identify the member.	All	100.0%	Administrative
89	DC088	Submitter-Specific Unique Subscriber ID	Text	50	Subscriber's unique ID	Use this field to report the identifier that the carrier/submitter uses internally to uniquely identify the subscriber.	All	100.0%	Administrative
90	DC089	Member Street Address (2)	Text	50	Secondary street address of the member	Use this field to report the second line of the member's street address, which may include apartment number, suite identifier, or other secondary information.	All	2.0%	837/2010BA/N3/ /02 837/2010CA/N3/ /02
91	DC090	Claim Line Type	Look-up Table - Text	1	Claim line activity type code	Use this field to report the code that defines the claim line status in terms of adjudication. The only valid codes for this field are: A = Amendment B = Back-Out O = Original R = Replacement V = Void	All	98.0%	Administrative
92	DC091	Former Claim Number	Text	35	Previous claim number	Use this field to report the Payer Claim Control Number (DC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own DC004. Use of the Former Claim Number field to version claims can only be used if approved by Connecticut.	All	0.0%	Administrative
93	DC092	Principal Diagnosis Code	Text	7	ICD principal diagnosis code	Use this field to report the ICD diagnosis for the principal diagnosis. Do not include the decimal point when coding this field.	All	99.0%	837/2300/HI/BK/01-2, 837/2300/HI/ABK/01-2

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold	Reference
94	DC093	ICD Version Indicator	Look-up Table - Integer	1	International Classification of Diseases (ICD) version	Use this field to report whether the diagnoses on the claim were coded using ICD-9 or ICD-10 codes. The only valid codes for this field are: 9 = ICD-9 0 = ICD-10	Required when DC092 is populated	100.0%	N/A
95	DC094	Denied Claim Indicator	Look-up Table - Integer	1	Denied claim line indicator	Use this field to report whether or not the claim line was denied. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%	Administrative
96	DC095	Denial Reason	External Code Source - HIPAA - OR- Carrier Look-up Table - Text	15	Denial reason code	Please report the code that defines the reason for the denial of the claim line using the externally maintained ASC X12 Claim Adjustment Reason Codes (CARCs), which can be found using the following URL: https://x12.org/codes/claim-adjustment-reason-codes Notes: If unable to report X12 CARCs, please continue to report using carrier-defined codes. If taking this approach, the submitter must provide Onpoint with a reference table of all non-standard values to support validation and use prior to submission.	Required when DC094 = 1	99.9%	835/2110/CAS
97	DC096	Payment Arrangement Indicator	Look-up Table - Integer	1	Payment arrangement type value	Use this field to report the value that defines the contracted payment methodology for this claim line. The only valid codes for this field are: 1 = Capitation 2 = Fee for Service 3 = Percent of Charges 4 = DRG 5 = Pay for Performance 6 = Global Payment 7 = Other 8 = Bundled Payment	All	98.0%	Administrative
98	DC097	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
99	DC098	APCD ID Code	Look-up Table - Integer	1	Member enrollment type	Use this field to report the value that describes the member's/subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate validations and thresholds. The only valid codes for this field are: 1 = Fully Insured Commercial Group Enrollee (FIG) 2 = Self-Insured Group Enrollee (SIG) 3 = State or Federal Employer Enrollee 4 = Individual - Non-Group Enrollee 5 = Supplemental Policy Enrollee 6 = Integrated Care Organization (ICO) 0 = Unknown / Not Applicable	All	100.0%	Administrative
100	DC099	Bill Frequency Code	External Code Source - NUBC - Text	1	Bill frequency code	Use this field to report the valid frequency code of the claim to indicate version, credit/debit activity, and/or setting of claim. Default value for dental claims is '1'.	All	100.0%	837/2300/CLM/ /05-3
101	DC899	Record Type	Text	2	File type identifier	This field must be coded 'DC' to indicate the submission of medical claims data. The value reported here must match across the following three fields: HD004, TR004, and DC899.	All	100.0%	Administrative

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
1	PV001	Submitter Code	Text	8	Submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match the value reported across all file types in the following fields: HD002, TR002, ME001, MC001, PC001, DC001, and PV001. Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter. Note, too, that the first two characters of the submitter code are used to indicate the client while the third character designates the type of submitter. For Connecticut's APCD collection, the only valid prefixes are: CTC = Commercial carrier CTG = Governmental agency CTT = Third-party administrator / pharmacy benefits manager	All	100.0%
2	PV002	Submitter-Specific Provider ID	Text	30	Unique carrier provider code	Report the submitter-assigned unique number for every provider (e.g., persons, facilities, or other entities involved in claims transactions) reported in the eligibility and claims files. This field should be reported consistent across the following fields: PV056, ME036, ME046 MC024, MC076, MC112, MC125, MC134, MC135, PC043, and DC018. Notes: This field may or may not contain the provider NPI, but must not contain the provider's Social Security number.	All	100.0%
3	PV003	Provider Tax ID	Text	9	Federal tax ID of non-individual providers	Report the federal Tax ID of the provider here. Do not use hyphen or alpha prefix.	Required when PV034 = 2, 3, 4, 5, 6, 7, or 0	98.0%
4	PV004	Provider UPIN ID	Text	6	Unique physician identification number	Report the Unique Physician Identification Number (UPIN) for the provider identified in the Submitter-Specific Provider ID field (PV002). To report other Medicare identifiers, use PV036.	Required when PV034 = 1	0.0%
5	PV005	Prescribing Provider DEA Number	Text	9	Provider DEA registration number	Report the valid U.S. Drug Enforcement Agency (DEA) registration number assigned to the individual, group, or facility identified in the Submitter-Specific Provider ID field (PV002). If not available or applicable, do not report any value here.	Required when PV034 = 1, 2, 3, 4, 5, or 0	50.0%
6	PV006	Provider License ID	Text	25	State practice license ID	Use this field to report the provider's state license number.	All	98.0%
8	PV008	Provider Last Name	Text	50	Last name of the provider identified in PV002	Report the individual provider's last name. Do not report any value here for facility or non-individual provider records. Report non-person entities in the Entity Name field (PV012).	Required when PV034 = 1	98.0%
9	PV009	Provider First Name	Text	50	First name of the provider identified in PV002	Report the individual provider's first name. Do not report any value here for facility or non-individual provider records. Report non-person entities in the Entity Name field (PV012).	Required when PV034 = 1	98.0%
10	PV010	Provider Middle Initial	Text	1	Middle initial of the provider identified in PV002	Report the individual's middle initial. Do not report any value here for facility or non-individual provider records. Report non-person entities the Entity Name field (PV012).	Required when PV034 = 1	1.0%
11	PV011	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
12	PV012	Entity Name	Text	100	Group/facility name	Use this field to report the name of the provider when not an individual person. This field should only be populated for facilities or groups. Punctuation may be included.	Required when PV034 = 2, 3, 4, 5, 6, 7, or 0	98.0%
14	PV014	Provider Gender Code	Look-up Table - Text	1	Gender of provider identified in PV002	Use this field to report the gender of the provider if an individual. The only valid codes for this field are: F = Female M = Male U = Unknown Notes: Set to null if the provider is a facility or an organization	Required when PV034 = 1	98.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
15	PV015	Provider Date of Birth	Integer	8	Birth date of the provider	Use this field to report the provider's date of birth (if an individual) using an 8-digit format of YYYYMMDD. Notes: Set to null if the provider is a facility or an organization.	Required when PV034 = 1	50.0%
16	PV016	Provider Physical Street Address (1)	Text	50	Street address 1 of the provider	Use this field to report the first line of the physical street address where the provider sees plan members. If only a mailing address is available, please report the mailing address in this field in addition to reporting it in the Provider Mailing Street Address (1) field (PV023). If the provider sees members at multiple locations, the provider should have a unique record for each to capture each site where the provider practices.	All	98.0%
17	PV017	Provider Physical Street Address (2)	Text	50	Street address 2 of the provider	Use this field to report the second line (if needed) of the physical street address where provider sees plan members. If only a mailing address is available, please report the mailing address in this field in addition to reporting it in the Provider Mailing Street Address (2) field (PV024). If the provider sees members at multiple locations, the provider should have a unique record for each to capture each site where the provider practices.	All	2.0%
18	PV018	Provider Physical City	Text	35	City of the provider	Report the city name of the site at which the provider sees plan members. If only a mailing address is available, please report the city name in this field in addition to reporting it in the Provider Mailing City field (PV025). If the provider sees members at multiple locations, the provider should have a unique record to capture each site where the provider practices.	All	98.0%
19	PV019	Provider Physical State	External Code Source - USPS - Text	2	State of the provider	Report the state of the site at which the provider sees plan members. If only a mailing address is available, please report the mailing state here in addition to reporting it in the Provider Mailing State field (PV026). When a provider sees patients at two or more locations, the provider should have a unique record for each location to capture all possible practice sites.	All	98.0%
20	PV020	Provider Physical Country Code	External Code Source - ANSI - Text	3	Country code of the provider	Report the three-character country code as defined by ISO 3166-1 alpha_3 of the site at which the provider sees plan members. If only a mailing address is available, please report the mailing country here in addition to reporting it in the Provider Mailing Country Code field (PV027). When a provider sees patients at multiple locations, the provider should have a unique record for each location to capture all possible practice sites.	All	98.0%
21	PV021	Provider Physical ZIP Code	External Code Source - USPS - Text	9	ZIP code of the provider	Use this field to report the ZIP code associated with the provider's location. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	98.0%
22	PV022	Provider Taxonomy Code (1)	External Code Source - WPC - Text	10	Taxonomy code	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of many types of clinicians, assistants, and technicians, where applicable, as well as physicians, nurses, groups, facilities, etc.	Required when PV034 = 1, 2, 3, 4, 5, or 0	75.0%
23	PV023	Provider Mailing Street Address (1)	Text	50	Street address of the provider/entity	Report the first line of the mailing address of the provider/entity identified in the Submitter-Specific Provider ID field (PV002).	All	98.0%
24	PV024	Provider Mailing Street Address (2)	Text	50	Secondary street address of the provider/entity	Report the second line of the mailing address of the provider/entity identified in the Submitter-Specific Provider ID field (PV002).	All	2.0%
25	PV025	Provider Mailing City	Text	35	City name of the provider/entity	Report the city of the mailing address of the provider/entity identified in the Submitter-Specific Provider ID field (PV002).	All	98.0%
26	PV026	Provider Mailing State	External Code Source - USPS - Text	2	State name of the provider/entity	Report the state of the mailing address of the provider/entity identified in the Submitter-Specific Provider ID field (PV002).	All	98.0%
27	PV027	Provider Mailing Country Code	External Code Source - USPS - Text	3	Country name of the provider/entity	Report the three-character country code as defined by ISO 3166-1 alpha_3.	All	98.0%
28	PV028	Provider Mailing ZIP Code	External Code Source - USPS - Text	9	ZIP code of the provider/entity	Use this field to report the ZIP code associated with the provider's mailing address. Notes: Include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP codes.	All	98.0%
30	PV030	Primary Specialty Code	External Code Source 4 -Text	2	Specialty code	Report the standard primary specialty code of the provider here.	Required when PV034 = 1, 2, 3, 4, 5, or 0	98.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
34	PV034	Entity Type Qualifier Code	Look-up Table - Integer	1	Provider identification code	Report the value that defines type of entity associated with provider identified in the Submitter-Specific Provider ID field (PV002). The value reported here drives intake validations for quality purposes. The only valid codes for this field are: 1 = Person; physician, clinician, orthodontist, and any individual that is licensed/certified to perform health care services. 2 = Facility; hospital, health center, long term care, rehabilitation and any building that is licensed to transact health care services. 3 = Professional Group; collection of licensed/certified health care professionals that are practicing health care services under the same entity name and Federal Tax Identification Number. 4 = Retail Site; brick-and-mortar licensed/certified place of transaction that is not solely a health care entity, i.e., pharmacies, independent laboratories, vision services. 5 = E-Site; internet-based order/logistic system of health care services, typically in the form of durable medical equipment, pharmacy or vision services. Address assigned should be the address of the company delivering services or order fulfillment. 6 = Financial Parent; financial governing body that does not perform health care services itself but directs and finances health care service entities, usually through a Board of Directors. 7 = Transportation; any form of transport that conveys a patient to/from a healthcare provider 0 = Other; any type of entity not otherwise defined that performs health care services.	All	100.0%
35	PV035	Individual Provider Social Security Number	Text	9	Provider's Social Security number (SSN)	Report the SSN of the individual provider identified in the Submitter-Specific Provider ID field (PV002). Do not zero-fill. Do not report any value here if not available or not applicable.	Required when PV034 = 1	98.0%
36	PV036	Provider Medicare ID	Text	30	Provider's Medicare number, other than UPIN	Report the Medicare ID (OSCAR, certification, other, unspecified, NSC, or PIN) of the provider or entity identified in the Submitter-Specific Provider ID field (PV002). Do not report UPIN here; instead, please report the UPIN also reported in the Provider UPIN ID field (PV004).	Required when PV034 = 1, 2, 3, 4, 5, or 0	50.0%
37	PV037	In-Network Date (Begin)	Integer	8	Provider start date	Report the date the provider becomes eligible / contracted to perform services as In-Network under any plan offering for plan members in YYYYMMDD format.	Required when PV064 = 1	100.0%
38	PV038	In-Network Date (End)	Integer	8	Provider end date	Report the date the provider is no longer eligible / contracted to perform services as in-network for all plan offerings for plan members in YYYYMMDD format. Annually contracted providers can report the contract end date here as a future date.	Required when PV064 = 1	10.0%
39	PV039	Provider NPI	External Code Source - NPPES - Text	10	National Provider Identifier (NPI) of the provider	Report the NPI of the provider/clinician/facility/organization defined in this record.	Required when PV034 = 1, 2, 3, 4, 5, or 0	98.0%
40	PV040	Provider NPI (Secondary)	External Code Source - NPPES - Text	10	Second National Provider Identifier (NPI) of the provider	Report the secondary or other NPI of the provider/clinician/facility/organization defined in this record.	Required when PV034 = 1, 2, 3, 4, 5, or 0	0.0%
41	PV041	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
42	PV042	Other Specialty Code (1)	Carrier-Defined Table - Text	10	Secondary specialty code	Report the submitter's proprietary specialty code for the provider here. Known additional specialty code for a provider should be populated in elements PV043 and PV044. Value comes from a carrier-defined table only. Submitters to provide a reference table for these values.	Required when PV034 = 1, 2, 3, 4, 5, or 0	1.0%
43	PV043	Other Specialty Code (2)	Carrier-Defined Table - OR - External Code Source 4 - Text	10	Other specialty code	Known additional specialty code for a provider should be populated in this field. Value can come from either a carrier-defined table or the external code source. If using carrier-defined codes, submitter must provide reference table of values.	Required when PV034 = 1, 2, 3, 4, 5, or 0	0.0%
44	PV044	Other Specialty Code (3)	Carrier-Defined Table - OR - External Code Source 4 - Text	10	Other specialty code	See mapping notes for Primary Specialty Code in PV030. Known additional specialty code for a provider should be populated in this field. Value can come from either a carrier-defined table or the external code source. If using carrier-defined codes, submitter must provide reference table of values.	Required when PV034 = 1, 2, 3, 4, 5, or 0	0.0%
44	PV045	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
45	PV046	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
47	PV047	Provider Uses Electronic Health Records Code	Look-up Table - Integer	1	Indicator – Electronic Health Record (HER) utilization	Use this field to report whether or not the provider uses electronic health records. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%
48	PV048	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
49	PV049	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
50	PV050	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
51	PV051	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
52	PV052	Provider with Multiple Offices Code	Look-up Table - Integer	1	Indicator - Multiple office provider	Use this field to report whether or not the provider uses multiple office locations. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Required when PV034 = 1, 2, or 3	100.0%
53	PV053	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
54	PV054	Submitter-Specific Medical Home ID	Text	30	Medical Home identification number	Report the identifier of the patient-centered medical home the provider is linked to here. The value in this field must have a corresponding Submitter-Specific Provider ID (PV002) in this or a previously submitted provider file.	Required when PV034 = 1, 2, or 3	0.0%
55	PV055	PCP Flag	Look-up Table - Integer	1	Indicator - Provider is a PCP	Use this field to report whether or not the provider is a primary care provider (PCP). The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Required when PV034 = 1	100.0%
56	PV056	Submitter-Specific Provider Affiliation ID	Text	30	Provider affiliation code	Report the Submitter-Specific Provider Affiliation ID for any affiliation the provider has with another entity or parent company. If the provider is associated only with self, record the same value here as reported in the Submitter-Specific Provider ID field (PV002).	All	99.0%
57	PV057	Provider Phone Number	Numeric	10	Telephone number associated with the provider identified in PV002	Report the telephone number of the provider identified in the Submitter-Specific Provider ID field (PV002). Do not separate components with hyphens, spaces, or other special characters.	All	10.0%
58	PV058	Delegated Provider Code	Integer	1	Indicator - Delegated record	Use this field to report whether or not this record pertains to a delegated provider. The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	All	100.0%
59	PV059	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
60	PV060	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
61	PV061	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
62	PV062	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%
63	PV063	Filler / Placeholder	Filler	0	Filler	The CT APCD reserves this field for future use. Do not populate with any data.	All	0.0%

Col. #	Element ID	Data Element Name	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Threshold
64	PV064	PPO Indicator	Look-up Table - Integer	1	Indicator - Provider PPO contract	Use this field to report whether or not the provider was participating as part of a preferred provider organization (PPO). The only valid codes for this field are: 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Required when PV034 = 1, 2, 3, 4, 5, or 0	100.0%
71	PV899	Record Type	Text	2	File type Identifier	This field must be coded 'PV' to indicate the submission of provider data. The value reported here must match across the following three fields: HD004, TR004, and PV899.	All	100.0%