DATA SUBMISSION TEMPLATE

OMB # 0938-1251/Expiration Date: XX/2020

Date Submitted		
Partner Name		
Contact Information		
Submitter Name		
Submitter Address		
Submitter Email Address		
Submitter Telephone Number		
Submission Information	**Default Response (change as needed)**	**Alternatives**
Media	Portal upload	Encrypted CD/DVD/Hard drive
Frequency	Monthly	Quarterly, Semi-annual
Estimated date of initial submission		
File format	Pipe-delimited CSV format	See Instructions
Data element differences	No	If Yes, enter on next sheet

Member/beneficiary identification type	Full SSN	See Instructions

11/23/2016 8:18 AM

TTP DEFAULT FORMATS FOR PROFESSIONAL CLAIMS

Seq	Professional Data Elements	Data Element Description	Data Type Format	Expected Values
1	Payer Name	Name of entity Providing source data	VARCHAR(40)	
2	File Type	The type of file being reported. (i.e. professional; Institutional; Pharmacy, Dental)	CHAR(2)	Professional=P Institutional-I Pharmacy =RX Dental=D
3	Line of Business	Payer Identifier and Line of Business	VARCHAR(40)	e.g., Medicare, Medicaid, Private, P&C
4	Claim Number	A unique number assigned by the payment system that identifies an original claim or an adjusted claim.	VARCHAR(20)	
5	Claim Line Number	Line number on the claim	INTEGER(3)	
6	Member ID	A unique identification number for the member.	VARCHAR(20)	
7	Member Social Security Number	Member's social security number (full 9 or last 4 numbers).	INTEGER	
8	Member Sex	The sex of the member	CHAR(1)	Male= M Female=F Unidentified=U
9	Member Date of Birth	Member's Date of Birth.	DATE	MM/DD/YYYY
10	Member State	Member's state	CHAR(2)	State Abbreviation
11	Member Zip Code	Member's zip code	INTEGER(5)	
12	Member DOD	Member's Date of Death.	DATE	MM/DD/YYYY
13	Rendering Provider Legal Business Name	Official name of rendering provider organization or if individual, in format LAST SUFFIX, FIRST MIDDLE	VARCHAR(100)	
14	Rendering Provider Doing Business As Name	Name provider renders services under or is known to public by for organizations or if individual, in format LAST SUFFIX, FIRST MIDDLE	VARCHAR(100)	
15	Rendering Provider NPI	The NPI for the provider who treated the member (as opposed to the provider "billing" for the service).	INTEGER(10)	
16	Rendering Provider TIN	Taxpayer Identification Number for provider who treated the member	INTEGER(10)	
17	Rendering Provider EIN	The EIN for the provider who treated the member	INTEGER(10)	
18	Rendering Provider Taxonomy	The taxonomy code for the provider who treated the member (as opposed to the provider "billing" for the service).	VARCHAR(10)	

19	Rendering Provider Specialty	Code that describes the area of specialty for the provider treating the member	VARCHAR	Please provide your specialty code definitions

Seq	Professional Data Elements	Data Element Description	Data Type Format	Expected Values
20	Rendering Provider Practice Address Line 1	US Address line 1 at which provider renders service	VARCHAR(100)	
21	Rendering Provider Practice Address Line 2	US Address line 2 at which provider renders service	VARCHAR(50)	
22	Rendering Provider Practice City	US City in which provider renders service	VARCHAR(50)	
23	Rendering Provider Practice State	US State in which provider renders service	CHAR(2)	State Abbreviation
24	Rendering Provider Practice Zip	USPS Zip Code in which provider renders service	INTEGER(5)	
25	Billing Provider Legal Business Name	Official name of billing provider organization or if individual, in format LAST SUFFIX, FIRST MIDDLE	VARCHAR(100)	
26	Billing Provider Doing Business As Name	Name billing provider is known to public by for organizations or if individual, in format LAST SUFFIX, FIRST MIDDLE	VARCHAR(100)	
27	Billing Provider TIN	Billing Provider Taxpayer Identification Number	INTEGER(10)	
28	Billing Provider Address Line 1	US Address line 1 that represents the entity billing address	VARCHAR(100)	
29	Billing Provider Address Line 2	US Address line 2 that represents the entity billing address	VARCHAR(50)	
30	Billing Provider City	US City for billing entity	VARCHAR(50)	
31	Billing Provider State	US State for billing entity	CHAR(2)	State Abbreviation
32	Billing Provider Zip	USPS Zip Code for billing entity	INTEGER(5)	
33	Referring Provider Legal Business Name	Official name of referring provider organization or if individual, in format LAST SUFFIX, FIRST MIDDLE	VARCHAR(100)	
34	Referring Provider Doing Business As Name	Name referring provider provides services under or is known to public by for organizations or if individual, in format LAST SUFFIX, FIRST MIDDLE	VARCHAR(100)	
35	Referring Provider NPI	NPI of Referring provider	INTEGER(10)	
36	Referring Provider TIN	Referring Taxpayer Identification Number	INTEGER(10)	
37	Referring Provider EIN	The EIN for the provider who referred the member	INTEGER(10)	
38	Referring Provider Practice Address Line 1	US Address line 1 at which provider referred service	VARCHAR(100)	

39	Referring Provider Practice Address Line 2	US Address line 2 at which provider referred service	VARCHAR(50)	
40	Referring Provider Practice City	US City in which provider referred service	VARCHAR(50)	
41	Referring Provider Practice State	US State in which provider referred service	CHAR(2)	State Abbreviation

Seq	Professional Data Elements	Data Element Description	Data Type Format	Expected Values
42	Referring Provider Practice Zip	USPS Zip Code in which provider referred service	INTEGER(5)	
43	Service/Procedure Code	The code per CPT, HCPCS **or NDC** used to indicate the service provided during the period covered by this claim.	VARCHAR(11)	
44	Service/Procedure Code Modifier	The modifier for the service code on this claim record. Modifier can be used to enhance the Service Code	VARCHAR(2)	
45	Modifier (2)	The 2nd modifier for the service code on this claim record. Modifier can be used to enhance the Service Code	VARCHAR(2)	
46	Modifier (3)	The 3rd modifier for the service code on this claim record. Modifier can be used to enhance the Service Code	VARCHAR(2)	
47	Modifier (4)	The 4th modifier for the service code on this claim record. Modifier can be used to enhance the Service Code	VARCHAR(2)	
48	Total Units/Quantity of Service	The number of units of service received by the recipient or units dispensed as shown on the claim record.	DECIMAL (5,2)	
49	Diagnosis Code 1	The ICD-9-CM/ ICD-10 code for the primary principal diagnosis for this claim. The principal diagnosis is the condition established after study to be chiefly responsible for the admission.	VARCHAR(8)	
50	Diagnosis Code 2	Second ICD-9-CM/ ICD-10-CM code found on the claim.	VARCHAR(8)	
51	Diagnosis Code 3	The third ICD-9-CM/ ICD-10 -CM codes that appear on the claim.	VARCHAR(8)	
52	Diagnosis Code 4	The fourth ICD-9-CM/ ICD-10-CM codes that appear on the claim.	VARCHAR(8)	
53	Diagnosis Type Code	Indicates if diagnosis code is ICD9-CM or ICD-10-CM	VARCHAR(8)	ICD9-CM or ICD10-CM
54	Place of Service	Code indicating where the service was performed	VARCHAR	
55	Beginning Date of Service	The first date of services received during an encounter with a provider, the date the service covered by this claim was received.	DATE	MM/DD/YYYY

56	Ending Date of Service	The last date of services received during an encounter with a provider, the date the service covered by this claim was received.	DATE	MM/DD/YYYY
57	Type of Service	A code indicating the type of service being billed. (if available-i.e. Transportation Services; Hospice, PCS etc. represented by a code)	VARCHAR	Please provide code definitions
58	Charged Amount	The total charge for this claim as submitted by the provider.	INTEGER	

Seq	Professional Data Elements	Data Element Description	Data Type Format	Expected Values
59	Amount Paid	The amount paid on this claim or adjustment.	INTEGER	
60	COB Amount	Coordination of Benefits amounts paid	INTEGER	
61	Claim Submission Date	The date on which the claim was submitted for payment	DATE	MM/DD/YYYY
62	Payment Adjudication Date	The date on which the payment status of the claim was paid	DATE	MM/DD/YYYY
63	Adjustment Indicator	Code indicating the type of adjustment record claim represented. (i.e. original claim, void, resubmittal, credit adjustment, debit adjustment, gross adjustment)	VARCHAR	Please provide code definitions

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1251. The time required to complete this information collection is estimated to average 120 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.