OMB control number: 0938-1187
Expiration Date: XX/XX/20XX

**Risk Adjustment Program and Payment Operations Data Requirements**

CMS will collect data required from issuers for the permanent Risk Adjustment program established by the Affordable Care Act of 2010. In addition, CMS will collect banking information to remit payments to applicable entities.

To ensure accurate information, consistent presentation, and minimize the burden on applicants, extensive analysis has been conducted to determine the minimum data necessary for administering the Risk Adjustment program and payment operations.

***Administrative Data Elements (as applicable)***
The section requests that issuers, self-insured and third party administrators when providing services on behalf of either provide basic information required to identify them to facilitate communications and necessary program operations. Data will be pre-populated from HIOS or other templates whenever possible.

Issuer, Self-Insured and TPA Data

1. HIOS Issuer ID
2. HIOS Company ID
3. State
4. Exchange Market Coverage
5. Company Legal Name
6. TIN
7. Not-for-Profit
8. NAIC Company Code
9. NAIC Group Code
10. Name of Holding Company
11. Legal Name
12. Marketing Name
13. Company Address: Address
14. Company Address: Address 2
15. Company Address: City
16. Company Address: State
17. Company Address: Zip Code
18. Issuer: Address
19. Issuer: Address 2
20. Issuer: City
21. Issuer: State
22. Issuer: Zip

Contacts

23. Main Company Contact: First Name
24. Main Company Contact: Last Name

25. Main Contact: E-mail
26. Main Company Contact: Phone Number
27. Main Company Contact: Phone Ext
28. CEO: First Name
29. CEO: Last Name
30. CEO: E-mail
31. CEO: Phone Number
32. CEO: Phone Ext
33. CFO: First Name
34. CFO: Last Name
35. CFO: E-mail
36. CFO: Phone Number
37. CFO: Phone Number Ext
38. Compliance Officer: First Name
39. Compliance Officer: Last Name
40. Compliance Officer: E-mail
41. Compliance Officer: Phone Number
42. Compliance Officer: Phone Number Ext
43. Compliance Officer: E-mail
44. Enrollment Contact: First Name
45. Enrollment Contact: Last Name
46. Enrollment Contact: Phone Number
47. Enrollment Contact: Phone Number Ext
48. Enrollment Contact: E-mail
49. System Contact: First Name
50. System Contact: Last Name
51. System Contact: Phone Number
52. System Contact: Phone Number Ext
53. System Contact: E-mail
54. Payment Contact: First Name
55. Payment Contact: Last Name
56. Payment Contact: Phone Number
57. Payment Contact: Phone Number Ext
58. Payment Contact: E-mail
59. HIPAA Security Officer: First Name
60. HIPAA Security Officer: Last Name
61. HIPAA Security Officer: Phone Number
62. HIPAA Security Officer: Phone Number Ext
63. HIPAA Security Officer: E-mail
64. Complaints Tracking Contact: First Name
65. Primary Contact: Individual or Small Group
66. Individual Market Contact: First Name
67. Individual Market Contact: Last Name
68. Individual Market Contact: Phone Number
69. Individual Market Contact: Phone Number Ext
70. Individual Market Contact: E-mail
71. SHOP Contact: First Name

72. SHOP Contact: Last Name
73. SHOP Contact: Phone Number
74. SHOP Contact: Phone Number Ext
75. SHOP Contact: E-mail
76. APTC/CSR Contact: First Name
77. APTC/CSR Contact: Last Name
78. APTC/CSR Contact: Phone Number
79. APTC/CSR Contact: Phone Number Ext
80. APTC/CSR Contact: Email
81. Risk Adjustment Contact: First Name
82. Risk Adjustment Contact: Last Name
83. Risk Adjustment Contact: Phone Number
84. Risk Adjustment Contact: Phone Number Ext
85. Risk Adjustment Contact: Email
86. Financial Transfers Contact: First Name
87. Financial Transfers Contact: Last Name
88. Financial Transfers Contact: Phone Number
89. Financial Transfers Contact: Phone Number Ext
90. Financial Transfers Contact: E-mail
91. Third Party Administrator (TPA) ID
92. Third Party Administrator (TPA) Name
93. Third Party Administrator (TPA) Process
94. Third Party Administrator (TPA) Process URL/EDI Gateway Info
95. Third Party Administrator (TPA) Confirmation of Services

Miscellaneous

96. Do you have a TPA that currently provides services for the following processes: Marketplace Enrollment (Y/N), Claims Processing (Y/N), Edge Server (Y/N)
97. Will you allow employees to "buy up" to a higher metal-level coverage than their employer is offering?

***State Licensure and Good Standing Documentation***

State licensure documentation necessary to demonstrate that an issuer is licensed and has authority to sell all applicable products in the services areas in which it intends to offer those products. If license and certificate of authority are not in possession for all service areas, attestation that license and certificate of authority will be obtained and a projected date of obtaining license.

Good standing documentation necessary to demonstrate that an issuer is in compliance with all applicable State solvency requirements and other relevant State regulatory requirements.

***Attestations (as applicable)***

1. The following applies to applicants participating in the risk adjustment program inside and/or outside of the Exchange (Marketplace). Applicant attests that it will:
   a) adhere to the risk adjustment standards and requirements set by HHS in theannual HHS notice of benefit and payment parameters (45 CFR Subparts G and H);
   b) remit charges to HHS under the circumstances described in 45 CFR 153.610;
   c) establish dedicated and secure server environments to host enrollee claims, encounter,

and enrollment information for the purpose of performing risk adjustment operations for all plans offered;

d) allow proper interface between the dedicated server environment and special, dedicated CMS resources that execute the risk adjustment operations;
e) ensure the transfer of timely, routine, and uniform data from local systems to the dedicated server environment using CMS-defined standards, including file formats and processing schedules;
f) comply with all information collection and reporting requirements approved through the Paperwork Reduction Act of 1995 and having a valid OMB control number for approved collections. The Issuer will submit all required information in a CMS-established manner and common data format;
g) cooperate with CMS, or its designee, through a process for establishing the server environment to implement these functions, including systems testing and operational readiness;
h) use sufficient security procedures to ensure that all data available electronically are authorized and protect all data from improper access, and ensure that the operations environment is restricted to only authorized users;
i) provide access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature to CMS or CMS' designee, if requested, for audit;
j) retain all original source documentation and medical records pertaining to any such particular claims data for a period of at least 10 years;
k) be responsible for all data submitted to CMS by itself, its employees, or its agents and based on best knowledge, information, and belief, submit data that are accurate, complete, and truthful;
l) all information, in any form whatsoever, exchanged for risk adjustment shall be employed solely for the purposes of operating the premium stabilization programs and financial programs associated with state markets, including but not limited to, the calculation of user fees to fund such programs, oversight, and any validation and analysis that CMS determines necessary;

2. Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim. 18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device, a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute. Applicant acknowledges the False Claims Act, 31 U.S.C. §§ 3729-3733.
3. Applicant attests to provide and promptly update when applicable changes occur in its Tax Identification Number (TIN) and associated legal entity name as registered with the Internal Revenue Service, financial institution account information, and any other

information needed by CMS in order for the applicant to receive invoices, demand letters, and payments under the risk adjustment program, as well as, any reconciliations of the aforementioned programs.

4. Applicant attests that it will develop, operate and maintain viable systems, processes, procedures and communication protocols to accept payment-related information submitted by CMS.

***Plan Data Elements (as applicable)***

The following is a list of the specific plan-level identification information to be provided for non-Exchange plans in the individual and small group market.

1. Plan ID
2. Plan Marketing Name
3. HIOS Product ID
4. Market Type
5. Exchange QHP? (Y/N)
   - If off-Exchange, is it the same or substantially the same as a certified Exchange QHP? Same, Substantially the same, No
   - If the same or substantially the same as a certified Exchange QHP, provide HIOS Plan ID (14-digit standard component) for the certified Exchange QHP.
6. Level of Coverage
7. Issuer calculated actuarial value?
8. Metal Level
9. Child–Only Offering
10. Child–Only Plan ID
11. Plan Type
12. New or Existing Plan Indicator
13. Plan Effective Date
14. Plan Expiration Date
15. Maximum Out–of–Pocket Individual In–Network for EHBs (combined amount for medical and drug)
16. Maximum Out–of–Pocket Family In–Network for EHBs (combined amount for medical and drug)
17. Federal Tax ID
18. Non-grandfathered (Y/N)
19. Type of Plan Offering: Student Health Plan (Y/N), Medicaid (Y/N), Basic Health Plan (Y/N), Excepted Benefit Plan-Not Standalone Dental (Y/N), Short Term Limited Duration Plan (Y/N), Other (Y/N)

***Rating Tables and Issuer Business Rules (as applicable)***

The following is a list of the specific rating table and issuer business rules data elements to be collected for non-Exchange plans in the individual and small group market.

1. Product ID
2. Plan ID (Standard Component)
3. Rate Effective Date
4. Rate Expiration Date
5. Rating Method

6. Is there a maximum age for a dependent?
7. How is age determined for rating and eligibility purposes?
8. How is tobacco status determined for subscribers and dependents?
9. What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?
10. Rating Area ID
11. Tobacco
12. Age
13. Individual Rate
14. Issuer ID
15. Product Level Rules
16. Plan Level Rules (14-digit number that identifies the plan)
17. Are you in a community rated state? (Y/N) If yes, are your premiums based on family tiering? (Y/N)
18. In which order are children rated, oldest to youngest or youngest to oldest?
19. What is the maximum number of underage dependents for this policy?
20. Medical, Dental, or Both Indicator
21. Medical or Dental Rule

***Banking Data (as applicable)***

The following is a list of the specific banking data to be collected from all entities eligible to receive payments.

1. Reason for Submission: New EFT Authorization (Y/N), Revision to Current Authorization (e.g. account or financial institution changes ) (Y/N)
2. Check here if EFT payment is being made to the Affiliate of the Entity (Attach letter authorizing EFT payments to the Affiliated Entity)
3. Since your last EFT authorization agreement submission, have you had a Change of Ownership and/or Change of Address? (Y/N) If yes, submit a change of information prior to accompanying this EFT authorization.
4. Entity ID
5. Vendor ID
6. HIOS ID
7. Entity name (Legal) – Legal entity name should be the same name provided to the Internal Revenue Service on Form W-9, Request for Taxpayer Identification Number (TIN) and Certification
8. Entity: Name (DBA)
9. Entity: Name (Division)
10. Entity: Address
11. Entity: Address 2 – Address should include routing information (e.g. Attention: Accounting Department)
12. Entity: City
13. Entity: State

14. Entity: Zip Code
15. Entity: Country
16. Entity: TIN
17. List of all Entity Affiliated HIOS IDs
18. List of all Entity Affiliated HIOS ID Names
19. List of all Entity Affiliated HPID IDs
20. IRS 1099: Address
21. IRS 1099: Address 2
22. IRS 1099: City
23. IRS 1099: State
24. IRS 1099: Zip Code
25. IRS 1099: Country
26. Copy of Voided Check
27. Letter from Financial Institution for Account Validation
28. Financial Institution Routing Transit Number
29. Entity Depositor Account Number
30. Type of Account: Checking or Savings
31. Payment Amount
32. Invoice Number
33. Invoice Date
34. Check Payment Remittance Contact: Title *(up to four instances)*
35. Check Payment Remittance Contact: First Name *(up to four instances)*
36. Check Payment Remittance Contact: Last Name *(up to four instances)*
37. Check Payment Remittance Contact: Phone Number *(up to four instances)*
38. Check Payment Remittance Contact: Phone Number Ext *(up to four instances)*
39. Check Payment Remittance Contact: E-mail *(up to four instances)*
40. Check Payment Remittance Contact: Address *(up to four instances)*
41. Check Payment Remittance Contact: Address 2 *(up to four instances)*
42. Check Payment Remittance Contact: City *(up to four instances)*
43. Check Payment Remittance Contact: State *(up to four instances)*
44. Check Payment Remittance Contact: Zip Code *(up to four instances)*
45. Check Payment Remittance Contact: Country (*up to four instances)*
46. EFT Banking Information: Title *(up to four instances)*
47. EFT Banking Information: First Name *(up to four instances)*
48. EFT Banking Information: Last Name *(up to four instances)*
49. EFT Banking Information: Phone Number *(up to four instances)*
50. EFT Banking Information: Phone Number Ext *(up to four instances)*
51. EFT Banking Information: E-mail *(up to four instances)*
52. EFT Banking Information: Bank Name *(up to four instances)*
53. EFT Banking Information: Address *(up to four instances)*
54. EFT Banking Information: Address 2 *(up to four instances)*
55. EFT Banking Information: City *(up to four instances)*
56. EFT Banking Information: State *(up to four instances)*
57. EFT Banking Information: Zip Code *(up to four instances)*
58. EFT Banking Information: Country *(up to four instances)*
59. Profit/Non-Profit Indicator
60. Change of Ownership Date

61. Business Line to which this banking information is applicable – Also referred to as "Business Line" or "Program Type;" includes FFM User Fees, Advanced Premium Tax Credits (APTC), Cost Sharing Reductions (CSR), , and Risk Adjustment programs.
62. Financial Reporting IP Address
63. Authorized/Delegated Official: Title
64. Authorized/Delegated Official: First Name
65. Authorized/Delegated Official: Last Name
66. Authorized/Delegated Official: Phone Number
67. Authorized/Delegated Official: Phone Number Ext
68. Authorized/Delegated Official: E-mail
69. Authorized/Delegated Official: Signature
70. Date of Authorization
71. Payment Contact: First Name
72. Payment Contact: Last Name
73. Payment Contact: Phone Number
74. Payment Contact: Phone Number Ext
75. Payment Contact: E-mail
76. Financial Transfers Contact: First Name
77. Financial Transfers Contact: Last Name
78. Financial Transfers Contact: Phone Number
79. Financial Transfers Contact: Phone Number Ext
80. Financial Transfers Contact: E-mail
81. Electronic Funds Transfer Authorization Agreement: I hereby authorize the Centers for Medicare & Medicaid Services (CMS) to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. CMS may assign its rights and obligations under this agreement to CMS' designated contractor. CMS may change its designated contractor at CMS' discretion. If payment is being made to an account controlled by an Affiliated Entity, referred to as Payee Group, the Entity, also known as Health Insurance Company, hereby acknowledges that payment to the Payee Group under these circumstances is still considered payment to the Health Insurance Company, and the Health Insurance Company authorizes the forwarding of payments to the Payee Group. If the account is drawn in the Health Insurance Company's name, or the Legal Business Name of the Health Insurance Company, the said Health Insurance Company certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Health Insurance Company are in accordance with all applicable CMS regulations and instructions. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CMS has received written notification from me of its termination in such time and such manner as to afford CMS and the Financial Institution a reasonable opportunity to act on it. CMS will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to CMS an updated signed EFT Authorization Agreement.
82. Are you an insurance company?

83. Effective Date for Financial Information
84. Financial Authority Contact: Title
85. Financial Authority Contact: First Name
86. Financial Authority Contact: Last Name
87. Financial Authority Contact: Phone Number
88. Financial Authority Contact: E-mail
89. Financial Institution: Name
90. Financial Institution: City
91. Financial Institution: State
92. Financial Institution: Zip
93. Financial Institution Contact: First Name
94. Financial Institution Contact: Last Name
95. Financial Institution Contact: Phone Number
96. Financial Institution Contact: Phone Number Ext
97. Financial Information Form Contact: First Name
98. Financial Information Form Contact: Last Name
99. Financial Information Form Contact: Title
100. Financial Information Form Contact: Phone Number
101. Financial Information Form Contact: Phone Number Ext
102. Financial Information Form Contact: Email
103. Payee Group: TIN
104. Payee Group Contact: Title
105. Payee Group Contact: First Name
106. Payee Group Contact: Last Name
107. Payee Group Contact: Phone Number
108. Payee Group Contact: Phone Number Ext
109. Payee Group Contact: Email
110. Payee Group Contact: Address
111. Payee Group Billing Address: Address
112. Payee Group Billing Address: Attention
113. Payee Group Billing Address: City
114. Payee Group Billing Address: State
115. Payee Group Billing Address: Zip Code
116. Is the payee group an Organization Level Payee?
117. Legal Business Name with no special characters except ampersands and hyphens
118. Type of Corporate Entity
119. Copy of W-9

***EDGE Server Registration and Provisioning Data***

The following is a list of the specific data required for the Edge Server registration and provisioning process.

**AWS EDGE Server Registration Data Elements**

**SECTION 1: ISSUER CONTACTS (primary and secondary are required)**

1. Primary Contact: Prefix (optional)
2. Primary Contact: First Name
3. Primary Contact: Last Name

4. Primary Contact: Job Title (optional)
5. Primary Contact: email address
6. Primary Contact: Phone Number
7. Primary Contact: Phone Number Ext
8. Secondary Contact: Prefix (optional)
9. Secondary Contact: First Name
10. Secondary Contact: Last Name
11. Secondary Contact: Job Title (optional)
12. Secondary Contact: email address
13. Secondary Contact: Phone Number
14. Secondary Contact: Phone Number Ext

**SECTION 2: ISSUER SUPPLEMENTAL CONTACTS (maximum of 2; optional)**

1. Supplemental Contact: Prefix (optional)
2. Supplemental Contact: First Name
3. Supplemental Contact: Last Name
4. Supplemental Contact: Job Title (optional)
5. Supplemental Contact: email address
6. Supplemental Contact: Phone Number
7. Supplemental Contact: Phone Number Ext
8. Supplemental Contact: Prefix (optional)
9. Supplemental Contact: First Name
10. Supplemental Contact: Last Name
11. Supplemental Contact: Job Title (optional)
12. Supplemental Contact: email address
13. Supplemental Contact: Phone Number
14. Supplemental Contact: Phone Number Ext

**SECTION 3: ISSUER AWS EDGE SERVER INFORMATION - SELF HOSTED**

1. Name of EDGE Server (provided by the Issuer)
2. Insurance Company - Legal name of the insurance company responsible for the EDGE Server
3. Issuer Name - Legal name of the issuer responsible for the EDGE Server
4. HIOS Issuer ID
5. EDGE Server Size - small, medium, or large
6. Amazon Web Services (AWS) Region - US East, US West - Oregon, US West – N. California
7. AWS Account Information – includes AWS account number for the registering organization and AWS Key Pair Name (AWS key name associated with the AWS account that is used to provision the EDGE server)

**SECTION 4: THIRD PARTY ADMINISTRATOR AWS EDGE SERVER INFORMATION - TPA HOSTED**

1. Name of EDGE Server
2. TPA Company - Legal name of the TPA company hosting the EDGE Server 3. Issuer Name - Legal name of the issuer responsible for the EDGE Server
4. TPA Identifier – (issuer selects from a list)
5. EDGE Server Size - small, medium, or large
6. Amazon Web Services (AWS) Region - US East, US West - Oregon, US West – N. California
7. AWS Account Information – includes AWS account number for the registering organization and AWS Key Pair Name (AWS key name associated with the AWS account that is used to provision the EDGE server)

**SECTION 5: TPA CONTACTS (primary and secondary required) - TPA HOSTED**

1. Primary Contact: Prefix (optional)
2. Primary Contact: First Name
3. Primary Contact: Last Name
4. Primary Contact: Job Title (optional)
5. Primary Contact: email address
6. Primary Contact: Phone Number
7. Primary Contact: Phone Number Ext
8. Secondary Contact: Prefix (optional)
9. Secondary Contact: First Name
10. Secondary Contact: Last Name
11. Secondary Contact: Job Title (optional)
12. Secondary Contact: email address
13. Secondary Contact: Phone Number
14. Secondary Contact: Phone Number Ext

**SECTION 6: TPA SUPPLEMENTAL CONTACTS (maximum of 2; optional) - TPA HOSTED**

1. Supplemental Contact: Prefix (optional)
2. Supplemental Contact: First Name
3. Supplemental Contact: Last Name
4. Supplemental Contact: Job Title (optional)
5. Supplemental Contact: email address
6. Supplemental Contact: Phone Number
7. Supplemental Contact: Phone Number Ext
8. Supplemental Contact: Prefix (optional)
9. Supplemental Contact: First Name
10. Supplemental Contact: Last Name
11. Supplemental Contact: Job Title (optional)
12. Supplemental Contact: email address
13. Supplemental Contact: Phone Number
14. Supplemental Contact: Phone Number Ext

**Issuer On-Premise EDGE Server Registration Data Elements**

**SECTION 1: ISSUER CONTACTS (primary and secondary are required)**

1. Primary Contact: Prefix (optional)
2. Primary Contact: First Name
3. Primary Contact: Last Name
4. Primary Contact: Job Title (optional)
5. Primary Contact: email address
6. Primary Contact: Phone Number
7. Primary Contact: Phone Number Ext
8. Secondary Contact: Prefix (optional)
9. Secondary Contact: First Name
10. Secondary Contact: Last Name
11. Secondary Contact: Job Title (optional)
12. Secondary Contact: email address
13. Secondary Contact: Phone Number

14. Secondary Contact: Phone Number Ext

**SECTION 2: ISSUER SUPPLEMENTAL CONTACTS (maximum of 2; optional)**

1. Supplemental Contact: Prefix (optional)
2. Supplemental Contact: First Name
3. Supplemental Contact: Last Name
4. Supplemental Contact: Job Title (optional)
5. Supplemental Contact: email address
6. Supplemental Contact: Phone Number
7. Supplemental Contact: Phone Number Ext
8. Supplemental Contact: Prefix (optional)
9. Supplemental Contact: First Name
10. Supplemental Contact: Last Name
11. Supplemental Contact: Job Title (optional)
12. Supplemental Contact: email address
13. Supplemental Contact: Phone Number
14. Supplemental Contact: Phone Number Ext

**SECTION 3: ISSUER EDGE SERVER INFORMATION - ON PREMISE SELF HOSTED**

1. Name of EDGE Server (provided by the Issuer)
2. Insurance Company - Legal name of the insurance company responsible for the EDGE Server 3. Issuer Name - Legal name of the issuer responsible for the EDGE Server 4. HIOS Issuer ID 5. EDGE Server Size - small, medium, or large

**SECTION 4: THIRD PARTY ADMINISTRATOR EDGE SERVER INFORMATION ON-PREMISE - TPA HOSTED**

1. Name of EDGE Server
2. TPA Company - Legal name of the TPA company hosting the EDGE Server 3. Issuer Name - Legal name of the issuer responsible for the EDGE Server
4. TPA Identifier - (issuer selects TPA from list)
5. EDGE Server Size - small, medium, or large

**SECTION 5: TPA CONTACTS (primary and secondary required) - TPA HOSTED**

1. Primary Contact: Prefix (optional)
2. Primary Contact: First Name
3. Primary Contact: Last Name
4. Primary Contact: Job Title (optional)
5. Primary Contact: email address
6. Primary Contact: Phone Number
7. Primary Contact: Phone Number Ext
8. Secondary Contact: Prefix (optional)
9. Secondary Contact: First Name
10. Secondary Contact: Last Name
11. Secondary Contact: Job Title (optional)
12. Secondary Contact: email address
13. Secondary Contact: Phone Number
14. Secondary Contact: Phone Number Ext

**SECTION 6: TPA SUPPLEMENTAL CONTACTS (maximum of 2; optional) - TPA HOSTED**

1. Supplemental Contact: Prefix (optional)

2. Supplemental Contact: First Name
3. Supplemental Contact: Last Name
4. Supplemental Contact: Job Title (optional)
5. Supplemental Contact:  email address
6. Supplemental Contact: Phone Number
7. Supplemental Contact: Phone Number Ext
8. Supplemental Contact: Prefix (optional)
9. Supplemental Contact: First Name
10. Supplemental Contact: Last Name
11. Supplemental Contact: Job Title (optional)
12. Supplemental Contact:  email address
13. Supplemental Contact: Phone Number
14. Supplemental Contact: Phone Number