Centers for Medicaid and CHIP Services (CMCS)

Transformed Medicaid Statistical Information Sys

Data Dictionary

Version: v4.0.0

Last Modified: 2024-06-03

PRA Disclosure Statement: The Transformed Medicaid Statistical Informat
and to calculate quality measures and other metrics, including those reported thro
this provision by requiring states to include data elements the Secretary determine
required to respond to a collection of information unless it displays a valid OMB co
search existing data resources, gather the data needed, and complete and review tl

tem (T-MSIS)

ion System (T-MSIS) is used to assist the Centers for Medicare & Medicaid Services (CM
ugh the new Medicaid and CHIP Scoreboard. Section 4735 of the Balanced Budget Act of 1997 inc
s necessary for program integrity, program oversight, and administration. Under the Privacy Act o
ntrol number. The valid OMB control number for this information collection is 0938-0345 (Expires
ne information collection. If you have comments concerning the accuracy of the time estimate(s) c

S) with monitoring and oversight of Medicaid and CHIP programs, to enable evaluation of
luded a statutory requirement for states to submit claims data, enrollee encounter data, and supp
f 1974 any personally identifying information obtained will be kept private to the extent of the law
: 03/31/2026). The time required to complete this information collection is estimated to average
or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA R

demonstrations under section 1115 of the Social Security Act
porting information. Section 6504 of the Affordable Care Act strengthened
w. According to the Paperwork Reduction Act of 1995, no persons are
10 hours per response, including the time to review instructions,
Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V4.0.0 - Data Dictionary

Note: The new financial

New Row Number	Data Element Number	System Data Element Number	Data Element	Data Element Name Text
1	CIP001	CIP.001.001	RECORD-ID	Record ID
2	CIP002	CIP.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version
3	CIP003	CIP.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type
4	CIP004	CIP.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification
5	CIP005	CIP.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version

6	CIP006	CIP.001.006	FILE-NAME	File Name
7	CIP007	CIP.001.007	SUBMITTING-STATE	Submitting State
8	CIP008	CIP.001.008	DATE-FILE-CREATED	Date File Created
9	CIP009	CIP.001.009	START-OF-TIME-PERIOD	Start of Time Period
10	CIP010	CIP.001.010	END-OF-TIME-PERIOD	End of Time Period
11	CIP011	CIP.001.011	FILE-STATUS-INDICATOR	File Status Indicator
12	CIP012	CIP.001.012	SSN-INDICATOR	SSN Indicator
13	CIP013	CIP.001.013	TOT-REC-CNT	Total Record Count

14	CIP275	CIP.001.275	SEQUENCE-NUMBER	Sequence Number
15	CIP014	CIP.001.014	STATE-NOTATION	State Notation
16	CIP016	CIP.002.016	RECORD-ID	Record ID
17	CIP017	CIP.002.017	SUBMITTING-STATE	Submitting State
18	CIP018	CIP.002.018	RECORD-NUMBER	Record Number
19	CIP019	CIP.002.019	ICN-ORIG	Original ICN
20	CIP020	CIP.002.020	ICN-ADJ	Adjustment ICN
21	CIP021	CIP.002.021	SUBMITTER-ID	Submitter ID

22	CIP022	CIP.002.022	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
23	CIP023	CIP.002.023	CROSSOVER-INDICATOR	Crossover Indicator
24	CIP024	CIP.002.024	TYPE-OF-HOSPITAL	Type of Hospital
25	CIP025	CIP.002.025	1115A-DEMONSTRATION-IND	1115A Demonstration Indicator
26	CIP026	CIP.002.026	ADJUSTMENT-IND	Adjustment Indicator
27	CIP027	CIP.002.027	ADJUSTMENT-REASON-CODE	Adjustment Reason Code
28	CIP028	CIP.002.028	ADMISSION-TYPE	Admission Type
29	CIP029	CIP.002.029	DRG-DESCRIPTION	DRG Description

30	CIP068	CIP.002.068	DIAGNOSIS-RELATED-GROUP	Diagnosis Related Group
31	CIP069	CIP.002.069	DIAGNOSIS-RELATED-GROUP-IND	Diagnosis Related Group Indicator
32	CIP070	CIP.002.070	PROCEDURE-CODE-1	Procedure Code 1
33	CIP072	CIP.002.072	PROCEDURE-CODE-FLAG-1	Procedure Code Flag 1
34	CIP073	CIP.002.073	PROCEDURE-CODE-DATE-1	Procedure Code Date 1

35	CIP074	CIP.002.074	PROCEDURE-CODE-2	Procedure Code 2
36	CIP076	CIP.002.076	PROCEDURE-CODE-FLAG-2	Procedure Code Flag 2
37	CIP077	CIP.002.077	PROCEDURE-CODE-DATE-2	Procedure Code Date 2
38	CIP078	CIP.002.078	PROCEDURE-CODE-3	Procedure Code 3
39	CIP080	CIP.002.080	PROCEDURE-CODE-FLAG-3	Procedure Code Flag 3

40	CIP081	CIP.002.081	PROCEDURE-CODE-DATE-3	Procedure Code Date 3
41	CIP082	CIP.002.082	PROCEDURE-CODE-4	Procedure Code 4
42	CIP084	CIP.002.084	PROCEDURE-CODE-FLAG-4	Procedure Code Flag 4
43	CIP085	CIP.002.085	PROCEDURE-CODE-DATE-4	Procedure Code Date 4
44	CIP086	CIP.002.086	PROCEDURE-CODE-5	Procedure Code 5

45	CIP088	CIP.002.088	PROCEDURE-CODE-FLAG-5	Procedure Code Flag 5
46	CIP089	CIP.002.089	PROCEDURE-CODE-DATE-5	Procedure Code Date 5
47	CIP090	CIP.002.090	PROCEDURE-CODE-6	Procedure Code 6
48	CIP092	CIP.002.092	PROCEDURE-CODE-FLAG-6	Procedure Code Flag 6
49	CIP093	CIP.002.093	PROCEDURE-CODE-DATE-6	Procedure Code Date 6

50	CIP094	CIP.002.094	ADMISSION-DATE	Admission Date
51	CIP095	CIP.002.095	ADMISSION-HOUR	Admission Hour
52	CIP096	CIP.002.096	DISCHARGE-DATE	Discharge Date
53	CIP097	CIP.002.097	DISCHARGE-HOUR	Discharge Hour
54	CIP098	CIP.002.098	ADJUDICATION-DATE	Adjudication Date
55	CIP099	CIP.002.099	MEDICAID-PAID-DATE	Medicaid Paid Date
56	CIP100	CIP.002.100	TYPE-OF-CLAIM	Type of Claim

57	CIP101	CIP.002.101	TYPE-OF-BILL	Type of Bill
58	CIP102	CIP.002.102	CLAIM-STATUS	Claim Status
59	CIP103	CIP.002.103	CLAIM-STATUS-CATEGORY	Claim Status Category
60	CIP104	CIP.002.104	SOURCE-LOCATION	Source Location
61	CIP105	CIP.002.105	CHECK-NUM	Check Number
62	CIP106	CIP.002.106	CHECK-EFF-DATE	Check Effective Date

63	CIP108	CIP.002.108	CLAIM-PYMT-REM-CODE-1	Remittance Advice Remark Code 1
64	CIP109	CIP.002.109	CLAIM-PYMT-REM-CODE-2	Remittance Advice Remark Code 2
65	CIP110	CIP.002.110	CLAIM-PYMT-REM-CODE-3	Remittance Advice Remark Code 3
66	CIP111	CIP.002.111	CLAIM-PYMT-REM-CODE-4	Remittance Advice Remark Code 4

67	CIP112	CIP.002.112	TOT-BILLED-AMT	Total Billed Amount
68	CIP113	CIP.002.113	TOT-ALLOWED-AMT	Total Allowed Amount
69	CIP114	CIP.002.114	TOT-MEDICAID-PAID-AMT	Total Medicaid Paid Amount

70	CIP116	CIP.002.116	TOT-MEDICARE-DEDUCTIBLE-AMT	Total Medicare Deductible Amount
71	CIP117	CIP.002.117	TOT-MEDICARE-COINS-AMT	Total Medicare Coinsurance Amount
72	CIP118	CIP.002.118	TOT-TPL-AMT	Total TPL Amount
73	CIP119	CIP.002.119	TOT-OTHER-INSURANCE-AMT	Total Other Insurance Amount
74	CIP121	CIP.002.121	OTHER-INSURANCE-IND	Other Insurance Indicator
75	CIP122	CIP.002.122	OTHER-TPL-COLLECTION	Other TPL Collection

76	CIP125	CIP.002.125	FIXED-PAYMENT-IND	Fixed Payment Indicator
77	CIP126	CIP.002.126	FUNDING-CODE	Funding Code
78	CIP127	CIP.002.127	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Non-Federal Share
79	CIP128	CIP.002.128	MEDICARE-COMB-DED-IND	Medicare Combined Deductible Indicator
80	CIP129	CIP.002.129	PROGRAM-TYPE	Program Type

81	CIP130	CIP.002.130	PLAN-ID-NUMBER	Plan ID Number
82	CIP132	CIP.002.132	PAYMENT-LEVEL-IND	Payment Level Indicator
83	CIP133	CIP.002.133	MEDICARE-REIM-TYPE	Medicare Reimbursement Type

84	CIP134	CIP.002.134	NON-COV-DAYS	Non-Covered Days
85	CIP135	CIP.002.135	NON-COV-CHARGES	Non-Covered Charges
86	CIP136	CIP.002.136	MEDICAID-COV-INPATIENT-DAYS	Medicaid Covered Inpatient Days
87	CIP137	CIP.002.137	CLAIM-LINE-COUNT	Claim Line Count
88	CIP138	CIP.002.138	FORCED-CLAIM-IND	Forced Claim Indicator
89	CIP139	CIP.002.139	HEALTH-CARE-ACQUIRED-CONDITION-IND	Healthcare Acquired Condition Indicator
90	CIP140	CIP.002.140	OCCURRENCE-CODE-01	Occurrence Code 1
91	CIP141	CIP.002.141	OCCURRENCE-CODE-02	Occurrence Code 2

92	CIP142	CIP.002.142	OCCURRENCE-CODE-03	Occurrence Code 3
93	CIP143	CIP.002.143	OCCURRENCE-CODE-04	Occurrence Code 4
94	CIP144	CIP.002.144	OCCURRENCE-CODE-05	Occurrence Code 5
95	CIP145	CIP.002.145	OCCURRENCE-CODE-06	Occurrence Code 6
96	CIP146	CIP.002.146	OCCURRENCE-CODE-07	Occurrence Code 7
97	CIP147	CIP.002.147	OCCURRENCE-CODE-08	Occurrence Code 8
98	CIP148	CIP.002.148	OCCURRENCE-CODE-09	Occurrence Code 9
99	CIP149	CIP.002.149	OCCURRENCE-CODE-10	Occurrence Code 10
100	CIP150	CIP.002.150	OCCURRENCE-CODE-EFF-DATE-01	Occurrence Code Effective Date 1
101	CIP151	CIP.002.151	OCCURRENCE-CODE-EFF-DATE-02	Occurrence Code Effective Date 2

102	CIP152	CIP.002.152	OCCURRENCE-CODE-EFF-DATE-03	Occurrence Code Effective Date 3
103	CIP153	CIP.002.153	OCCURRENCE-CODE-EFF-DATE-04	Occurrence Code Effective Date 4
104	CIP154	CIP.002.154	OCCURRENCE-CODE-EFF-DATE-05	Occurrence Code Effective Date 5
105	CIP155	CIP.002.155	OCCURRENCE-CODE-EFF-DATE-06	Occurrence Code Effective Date 6
106	CIP156	CIP.002.156	OCCURRENCE-CODE-EFF-DATE-07	Occurrence Code Effective Date 7
107	CIP157	CIP.002.157	OCCURRENCE-CODE-EFF-DATE-08	Occurrence Code Effective Date 8
108	CIP158	CIP.002.158	OCCURRENCE-CODE-EFF-DATE-09	Occurrence Code Effective Date 9
109	CIP159	CIP.002.159	OCCURRENCE-CODE-EFF-DATE-10	Occurrence Code Effective Date 10
110	CIP160	CIP.002.160	OCCURRENCE-CODE-END-DATE-01	Occurrence Code End Date 1

111	CIP161	CIP.002.161	OCCURRENCE-CODE-END-DATE-02	Occurrence Code End Date 2
112	CIP162	CIP.002.162	OCCURRENCE-CODE-END-DATE-03	Occurrence Code End Date 3
113	CIP163	CIP.002.163	OCCURRENCE-CODE-END-DATE-04	Occurrence Code End Date 4
114	CIP164	CIP.002.164	OCCURRENCE-CODE-END-DATE-05	Occurrence Code End Date 5
115	CIP165	CIP.002.165	OCCURRENCE-CODE-END-DATE-06	Occurrence Code End Date 6
116	CIP166	CIP.002.166	OCCURRENCE-CODE-END-DATE-07	Occurrence Code End Date 7
117	CIP167	CIP.002.167	OCCURRENCE-CODE-END-DATE-08	Occurrence Code End Date 8
118	CIP168	CIP.002.168	OCCURRENCE-CODE-END-DATE-09	Occurrence Code End Date 9
119	CIP169	CIP.002.169	OCCURRENCE-CODE-END-DATE-10	Occurrence Code End Date 10
120	CIP170	CIP.002.170	BIRTH-WEIGHT-GRAMS	Birth Weight Grams
121	CIP171	CIP.002.171	PATIENT-CONTROL-NUM	Patient Control Number

122	CIP172	CIP.002.172	ELIGIBLE-LAST-NAME	Eligible Last Name
123	CIP173	CIP.002.173	ELIGIBLE-FIRST-NAME	Eligible First Name
124	CIP174	CIP.002.174	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial
125	CIP175	CIP.002.175	DATE-OF-BIRTH	Date of Birth
126	CIP176	CIP.002.176	HEALTH-HOME-PROV-IND	Health Home Provider Indicator
127	CIP177	CIP.002.177	WAIVER-TYPE	Waiver Type
128	CIP178	CIP.002.178	WAIVER-ID	Waiver ID

129	CIP179	CIP.002.179	BILLING-PROV-NUM	Billing Provider Number
130	CIP180	CIP.002.180	BILLING-PROV-NPI-NUM	Billing Provider NPI Number
131	CIP181	CIP.002.181	BILLING-PROV-TAXONOMY	Billing Provider Taxonomy
132	CIP182	CIP.002.182	BILLING-PROV-TYPE	Billing Provider Type
133	CIP183	CIP.002.183	BILLING-PROV-SPECIALTY	Billing Provider Specialty
134	CIP184	CIP.002.184	ADMITTING-PROV-NPI-NUM	Admitting Provider NPI Number
135	CIP185	CIP.002.185	ADMITTING-PROV-NUM	Admitting Provider Number
136	CIP186	CIP.002.186	ADMITTING-PROV-SPECIALTY	Admitting Provider Specialty

137	CIP187	CIP.002.187	ADMITTING-PROV-TAXONOMY	Admitting Provider Taxonomy
138	CIP188	CIP.002.188	ADMITTING-PROV-TYPE	Admitting Provider Type
139	CIP189	CIP.002.189	REFERRING-PROV-NUM	Referring Provider Number
140	CIP190	CIP.002.190	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number
141	CIP194	CIP.002.194	DRG-OUTLIER-AMT	DRG Outlier Amount
142	CIP195	CIP.002.195	DRG-REL-WEIGHT	DRG Relative Weight
143	CIP196	CIP.002.196	MEDICARE-HIC-NUM	Medicare HIC Number

144	CIP197	CIP.002.197	OUTLIER-CODE	Outlier Code
145	CIP198	CIP.002.198	OUTLIER-DAYS	Outlier Days
146	CIP199	CIP.002.199	PATIENT-STATUS	Patient Status
147	CIP202	CIP.002.202	REMITTANCE-NUM	Remittance Number
148	CIP203	CIP.002.203	SPLIT-CLAIM-IND	Split Claim Indicator
149	CIP204	CIP.002.204	BORDER-STATE-IND	Border State Indicator
150	CIP206	CIP.002.206	TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT	Beneficiary Coinsurance Paid Amount
151	CIP207	CIP.002.207	BENEFICIARY-COINSURANCE-DATE-PAID	Beneficiary Coinsurance Date Paid
152	CIP208	CIP.002.208	TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT	Total Beneficiary Copayment Paid Amount
153	CIP209	CIP.002.209	BENEFICIARY-COPAYMENT-DATE-PAID	Beneficiary Copayment Date Paid

154	CIP210	CIP.002.210	TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT	Total Beneficiary Deductible Paid Amount
155	CIP211	CIP.002.211	BENEFICIARY-DEDUCTIBLE-DATE-PAID	Beneficiary Deductible Date Paid
156	CIP212	CIP.002.212	CLAIM-DENIED-INDICATOR	Claim Denied Indicator
157	CIP213	CIP.002.213	COPAY-WAIVED-IND	Copayment Waived Indicator
158	CIP214	CIP.002.214	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name
159	CIP216	CIP.002.216	THIRD-PARTY-COINSURANCE-AMOUNT-PAID	Third Party Coinsurance Amount Paid
160	CIP217	CIP.002.217	THIRD-PARTY-COINSURANCE-DATE-PAID	Third Party Coinsurance Date Paid
161	CIP218	CIP.002.218	THIRD-PARTY-COPAYMENT-AMOUNT-PAID	Third Party Copayment Amount Paid
162	CIP219	CIP.002.219	THIRD-PARTY-COPAYMENT-DATE-PAID	Third Party Copayment Date Paid

163	CIP220	CIP.002.220	MEDICAID-AMOUNT-PAID-DSH	Medicaid Amount Paid DSH
164	CIP221	CIP.002.221	HEALTH-HOME-PROVIDER-NPI	Health Home Provider NPI Number
165	CIP222	CIP.002.222	MEDICARE-BENEFICIARY-IDENTIFIER	Medicare Beneficiary Identifier
166	CIP223	CIP.002.223	OPERATING-PROV-TAXONOMY	Operating Provider Taxonomy
167	CIP228	CIP.002.228	MEDICARE-PAID-AMT	Medicare Paid Amount

168	CIP289	CIP.002.289	PROV-LOCATION-ID	Provider Location ID
169	CIP290	CIP.002.290	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service
170	CIP291	CIP.002.291	ENDING-DATE-OF-SERVICE	Ending Date of Service
171	CIP292	CIP.002.292	TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT	Total Beneficiary Copayment Liable Amount
172	CIP293	CIP.002.293	TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT	Total Beneficiary Coinsurance Liable Amount

173	CIP294	CIP.002.294	TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT	Total Beneficiary Deductible Liable Amount
174	CIP295	CIP.002.295	COMBINED-BENE-COST-SHARING-PAID-AMOUNT	Combined Beneficiary Cost Sharing Paid Amount
175	CIP297	CIP.002.297	LTC-RCP-LIAB-AMT	LTC RCP Liability Amount
176	CIP298	CIP.002.298	BILLING-PROV-ADDR-LN-1	Billing Provider Address Line 1
177	CIP299	CIP.002.299	BILLING-PROV-ADDR-LN-2	Billing Provider Address Line 2
178	CIP300	CIP.002.300	BILLING-PROV-CITY	Billing Provider City
179	CIP301	CIP.002.301	BILLING-PROV-STATE	Billing Provider State Code
180	CIP302	CIP.002.302	BILLING-PROV-ZIP-CODE	Billing Provider ZIP Code
181	CIP303	CIP.002.303	SERVICE-FACILITY-LOCATION-ORG-NPI	Service Facility Location Organization NPI
182	CIP304	CIP.002.304	SERVICE-FACILITY-LOCATION-ADDR-LN-1	Service Facility Location Address Line 1

183	CIP305	CIP.002.305	SERVICE-FACILITY-LOCATION-ADDR-LN-2	Service Facility Location Address Line 2
184	CIP306	CIP.002.306	SERVICE-FACILITY-LOCATION-CITY	Service Facility Location City
185	CIP307	CIP.002.307	SERVICE-FACILITY-LOCATION-STATE	Service Facility Location State
186	CIP308	CIP.002.308	SERVICE-FACILITY-LOCATION-ZIP-CODE	Service Facility Location ZIP Code
187	CIP309	CIP.002.309	PROVIDER-CLAIM-FORM-CODE	Provider Claim Form Code
188	CIP310	CIP.002.310	PROVIDER-CLAIM-FORM-OTHER-TEXT	Provider Claim Form Other Text
189	CIP311	CIP.002.311	TOT-GME-AMOUNT-PAID	Total GME Amount Paid
190	CIP338	CIP.002.338	TOT-SDP-ALLOWED-AMT	Total State Directed Payment Allowed Amount
191	CIP339	CIP.002.339	TOT-SDP-PAID-AMT	Total State Directed Payment Paid Amount
192	CIP229	CIP.002.229	STATE-NOTATION	State Notation

193	CIP231	CIP.003.231	RECORD-ID	Record ID
194	CIP232	CIP.003.232	SUBMITTING-STATE	Submitting State
195	CIP233	CIP.003.233	RECORD-NUMBER	Record Number
196	CIP234	CIP.003.234	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
197	CIP235	CIP.003.235	ICN-ORIG	Original ICN
198	CIP236	CIP.003.236	ICN-ADJ	Adjustment ICN
199	CIP237	CIP.003.237	LINE-NUM-ORIG	Original Line Number

200	CIP238	CIP.003.238	LINE-NUM-ADJ	Adjustment Line Number
201	CIP239	CIP.003.239	LINE-ADJUSTMENT-IND	Line Adjustment Indicator
202	CIP240	CIP.003.240	LINE-ADJUSTMENT-REASON-CODE	Line Adjustment Reason Code
203	CIP241	CIP.003.241	SUBMITTER-ID	Submitter ID
204	CIP242	CIP.003.242	CLAIM-LINE-STATUS	Claim Line Status
205	CIP243	CIP.003.243	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service

206	CIP244	CIP.003.244	ENDING-DATE-OF-SERVICE	Ending Date of Service
207	CIP245	CIP.003.245	REVENUE-CODE	Revenue Code
208	CIP249	CIP.003.249	REVENUE-CENTER-QUANTITY-ACTUAL	Revenue Center Quantity Actual
209	CIP250	CIP.003.250	REVENUE-CENTER-QUANTITY-ALLOWED	Revenue Center Quantity Allowed

210	CIP251	CIP.003.251	REVENUE-CHARGE	Revenue Charge
211	CIP252	CIP.003.252	ALLOWED-AMT	Allowed Amount
212	CIP254	CIP.003.254	MEDICAID-PAID-AMT	Medicaid Paid Amount
213	CIP255	CIP.003.255	MEDICAID-FFS-EQUIVALENT-AMT	Medicaid FFS Equivalent Amount

214	CIP256	CIP.003.256	BILLING-UNIT	Billing Unit
215	CIP257	CIP.003.257	TYPE-OF-SERVICE	Type of Service
216	CIP260	CIP.003.260	SERVICING-PROV-NUM	Servicing Provider Number
217	CIP261	CIP.003.261	SERVICING-PROV-NPI-NUM	Servicing Provider NPI Number
218	CIP263	CIP.003.263	SERVICING-PROV-TYPE	Servicing Provider Type
219	CIP264	CIP.003.264	SERVICING-PROV-SPECIALTY	Servicing Provider Specialty
220	CIP265	CIP.003.265	OPERATING-PROV-NPI-NUM	Operating Provider NPI Number
221	CIP266	CIP.003.266	OTHER-TPL-COLLECTION	Other TPL Collection
222	CIP267	CIP.003.267	PROV-FACILITY-TYPE	Provider Facility Type

223	CIP269	CIP.003.269	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
224	CIP272	CIP.003.272	OTHER-INSURANCE-AMT	Other Insurance Amount
225	CIP278	CIP.003.278	NDC-QUANTITY	NDC Quantity
226	CIP284	CIP.003.284	NATIONAL-DRUG-CODE	National Drug Code
227	CIP285	CIP.003.285	NDC-UNIT-OF-MEASURE	NDC Unit of Measure
228	CIP286	CIP.003.286	ADJUDICATION-DATE	Adjudication Date
229	CIP287	CIP.003.287	SELF-DIRECTION-TYPE	Self Direction Type
230	CIP288	CIP.003.288	PRE-AUTHORIZATION-NUM	Preauthorization Number
231	CIP296	CIP.003.296	IHS-SERVICE-IND	IHS Service Indicator
232	CIP314	CIP.003.314	UNIQUE-DEVICE-IDENTIFIER	Unique Device Identifier

233	CIP340	CIP.003.340	MBESCBES-FORM-GROUP	MBESCBES Form Group
234	CIP316	CIP.003.316	MBESCBES-FORM	MBESCBES Form
235	CIP315	CIP.003.315	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service
236	CIP317	CIP.003.317	GME-AMOUNT-PAID	GME Amount Paid

237	CIP318	CIP.003.318	REFERRING-PROV-NUM	Referring Provider Number
238	CIP319	CIP.003.319	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number
239	CIP336	CIP.003.336	SDP-ALLOWED-AMT	State Directed Payment Allowed Amount
240	CIP337	CIP.003.337	SDP-PAID-AMT	State Directed Payment Paid Amount
241	CIP273	CIP.003.273	STATE-NOTATION	State Notation
242	CIP322	CIP.004.322	RECORD-ID	Record ID
243	CIP323	CIP.004.323	SUBMITTING-STATE	Submitting State
244	CIP324	CIP.004.324	RECORD-NUMBER	Record Number
245	CIP325	CIP.004.325	ICN-ORIG	Original ICN

246	CIP326	CIP.004.326	ICN-ADJ	Adjustment ICN
247	CIP327	CIP.004.327	ADJUSTMENT-IND	Adjustment Indicator
248	CIP328	CIP.004.328	ADJUDICATION-DATE	Adjudication Date
249	CIP329	CIP.004.329	DIAGNOSIS-TYPE	Diagnosis Type
250	CIP330	CIP.004.330	DIAGNOSIS-SEQUENCE-NUMBER	Diagnosis Sequence Number
251	CIP331	CIP.004.331	DIAGNOSIS-CODE-FLAG	Diagnosis Code Flag
252	CIP332	CIP.004.332	DIAGNOSIS-CODE	Diagnosis Code

253	CIP333	CIP.004.333	DIAGNOSIS-POA-FLAG	Diagnosis POA Flag
254	CIP334	CIP.004.334	STATE-NOTATION	State Notation
255	CLT001	CLT.001.001	RECORD-ID	Record ID
256	CLT002	CLT.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version
257	CLT003	CLT.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type
258	CLT004	CLT.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification
259	CLT005	CLT.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version
260	CLT006	CLT.001.006	FILE-NAME	File Name
261	CLT007	CLT.001.007	SUBMITTING-STATE	Submitting State

262	CLT008	CLT.001.008	DATE-FILE-CREATED	Date File Created
263	CLT009	CLT.001.009	START-OF-TIME-PERIOD	Start of Time Period
264	CLT010	CLT.001.010	END-OF-TIME-PERIOD	End of Time Period
265	CLT011	CLT.001.011	FILE-STATUS-INDICATOR	File Status Indicator
266	CLT012	CLT.001.012	SSN-INDICATOR	SSN Indicator
267	CLT013	CLT.001.013	TOT-REC-CNT	Total Record Count
268	CLT227	CLT.001.227	SEQUENCE-NUMBER	Sequence Number
269	CLT014	CLT.001.014	STATE-NOTATION	State Notation

270	CLT016	CLT.002.016	RECORD-ID	Record ID
271	CLT017	CLT.002.017	SUBMITTING-STATE	Submitting State
272	CLT018	CLT.002.018	RECORD-NUMBER	Record Number
273	CLT019	CLT.002.019	ICN-ORIG	Original ICN
274	CLT020	CLT.002.020	ICN-ADJ	Adjustment ICN
275	CLT021	CLT.002.021	SUBMITTER-ID	Submitter ID
276	CLT022	CLT.002.022	MSIS-IDENTIFICATION-NUM	MSIS Identification Number

277	CLT023	CLT.002.023	CROSSOVER-INDICATOR	Crossover Indicator
278	CLT024	CLT.002.024	1115A-DEMONSTRATION-IND	1115A Demonstration Indicator
279	CLT025	CLT.002.025	ADJUSTMENT-IND	Adjustment Indicator
280	CLT026	CLT.002.026	ADJUSTMENT-REASON-CODE	Adjustment Reason Code
281	CLT044	CLT.002.044	ADMISSION-DATE	Admission Date
282	CLT045	CLT.002.045	ADMISSION-HOUR	Admission Hour

283	CLT046	CLT.002.046	DISCHARGE-DATE	Discharge Date
284	CLT047	CLT.002.047	DISCHARGE-HOUR	Discharge Hour
285	CLT048	CLT.002.048	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service
286	CLT049	CLT.002.049	ENDING-DATE-OF-SERVICE	Ending Date of Service
287	CLT050	CLT.002.050	ADJUDICATION-DATE	Adjudication Date
288	CLT051	CLT.002.051	MEDICAID-PAID-DATE	Medicaid Paid Date

289	CLT052	CLT.002.052	TYPE-OF-CLAIM	Type of Claim
290	CLT053	CLT.002.053	TYPE-OF-BILL	Type of Bill
291	CLT054	CLT.002.054	CLAIM-STATUS	Claim Status
292	CLT055	CLT.002.055	CLAIM-STATUS-CATEGORY	Claim Status Category
293	CLT056	CLT.002.056	SOURCE-LOCATION	Source Location
294	CLT057	CLT.002.057	CHECK-NUM	Check Number
295	CLT058	CLT.002.058	CHECK-EFF-DATE	Check Effective Date

296	CLT059	CLT.002.059	CLAIM-PYMT-REM-CODE-1	Remittance Advice Remark Code 1
297	CLT060	CLT.002.060	CLAIM-PYMT-REM-CODE-2	Remittance Advice Remark Code 2
298	CLT061	CLT.002.061	CLAIM-PYMT-REM-CODE-3	Remittance Advice Remark Code 3
299	CLT062	CLT.002.062	CLAIM-PYMT-REM-CODE-4	Remittance Advice Remark Code 4

300	CLT063	CLT.002.063	TOT-BILLED-AMT	Total Billed Amount
301	CLT064	CLT.002.064	TOT-ALLOWED-AMT	Total Allowed Amount
302	CLT065	CLT.002.065	TOT-MEDICAID-PAID-AMT	Total Medicaid Paid Amount

303	CLT067	CLT.002.067	TOT-MEDICARE-DEDUCTIBLE-AMT	Total Medicare Deductible Amount
304	CLT068	CLT.002.068	TOT-MEDICARE-COINS-AMT	Total Medicare Coinsurance Amount
305	CLT069	CLT.002.069	TOT-TPL-AMT	Total TPL Amount
306	CLT070	CLT.002.070	TOT-OTHER-INSURANCE-AMT	Total Other Insurance Amount
307	CLT071	CLT.002.071	OTHER-INSURANCE-IND	Other Insurance Indicator
308	CLT072	CLT.002.072	OTHER-TPL-COLLECTION	Other TPL Collection

309	CLT075	CLT.002.075	FIXED-PAYMENT-IND	Fixed Payment Indicator
310	CLT076	CLT.002.076	FUNDING-CODE	Funding Code
311	CLT077	CLT.002.077	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Non-Federal Share
312	CLT078	CLT.002.078	MEDICARE-COMB-DED-IND	Medicare Combined Deductible Indicator
313	CLT079	CLT.002.079	PROGRAM-TYPE	Program Type

314	CLT080	CLT.002.080	PLAN-ID-NUMBER	Plan ID Number
315	CLT082	CLT.002.082	PAYMENT-LEVEL-IND	Payment Level Indicator

316	CLT083	CLT.002.083	MEDICARE-REIM-TYPE	Medicare Reimbursement Type
317	CLT084	CLT.002.084	NON-COV-DAYS	Non-Covered Days
318	CLT085	CLT.002.085	NON-COV-CHARGES	Non-Covered Charges
319	CLT086	CLT.002.086	MEDICAID-COV-INPATIENT-DAYS	Medicaid Covered Inpatient Days
320	CLT087	CLT.002.087	CLAIM-LINE-COUNT	Claim Line Count
321	CLT090	CLT.002.090	FORCED-CLAIM-IND	Forced Claim Indicator
322	CLT091	CLT.002.091	HEALTH-CARE-ACQUIRED-CONDITION-IND	Healthcare Acquired Condition Indicator
323	CLT092	CLT.002.092	OCCURRENCE-CODE-01	Occurrence Code 1

324	CLT093	CLT.002.093	OCCURRENCE-CODE-02	Occurrence Code 2
325	CLT094	CLT.002.094	OCCURRENCE-CODE-03	Occurrence Code 3
326	CLT095	CLT.002.095	OCCURRENCE-CODE-04	Occurrence Code 4
327	CLT096	CLT.002.096	OCCURRENCE-CODE-05	Occurrence Code 5
328	CLT097	CLT.002.097	OCCURRENCE-CODE-06	Occurrence Code 6
329	CLT098	CLT.002.098	OCCURRENCE-CODE-07	Occurrence Code 7
330	CLT099	CLT.002.099	OCCURRENCE-CODE-08	Occurrence Code 8
331	CLT100	CLT.002.100	OCCURRENCE-CODE-09	Occurrence Code 9
332	CLT101	CLT.002.101	OCCURRENCE-CODE-10	Occurrence Code 10
333	CLT102	CLT.002.102	OCCURRENCE-CODE-EFF-DATE-01	Occurrence Code Effective Date 1

334	CLT103	CLT.002.103	OCCURRENCE-CODE-EFF-DATE-02	Occurrence Code Effective Date 2
335	CLT104	CLT.002.104	OCCURRENCE-CODE-EFF-DATE-03	Occurrence Code Effective Date 3
336	CLT105	CLT.002.105	OCCURRENCE-CODE-EFF-DATE-04	Occurrence Code Effective Date 4
337	CLT106	CLT.002.106	OCCURRENCE-CODE-EFF-DATE-05	Occurrence Code Effective Date 5
338	CLT107	CLT.002.107	OCCURRENCE-CODE-EFF-DATE-06	Occurrence Code Effective Date 6
339	CLT108	CLT.002.108	OCCURRENCE-CODE-EFF-DATE-07	Occurrence Code Effective Date 7
340	CLT109	CLT.002.109	OCCURRENCE-CODE-EFF-DATE-08	Occurrence Code Effective Date 8
341	CLT110	CLT.002.110	OCCURRENCE-CODE-EFF-DATE-09	Occurrence Code Effective Date 9
342	CLT111	CLT.002.111	OCCURRENCE-CODE-EFF-DATE-10	Occurrence Code Effective Date 10

343	CLT112	CLT.002.112	OCCURRENCE-CODE-END-DATE-01	Occurrence Code End Date 1
344	CLT113	CLT.002.113	OCCURRENCE-CODE-END-DATE-02	Occurrence Code End Date 2
345	CLT114	CLT.002.114	OCCURRENCE-CODE-END-DATE-03	Occurrence Code End Date 3
346	CLT115	CLT.002.115	OCCURRENCE-CODE-END-DATE-04	Occurrence Code End Date 4
347	CLT116	CLT.002.116	OCCURRENCE-CODE-END-DATE-05	Occurrence Code End Date 5
348	CLT117	CLT.002.117	OCCURRENCE-CODE-END-DATE-06	Occurrence Code End Date 6
349	CLT118	CLT.002.118	OCCURRENCE-CODE-END-DATE-07	Occurrence Code End Date 7
350	CLT119	CLT.002.119	OCCURRENCE-CODE-END-DATE-08	Occurrence Code End Date 8
351	CLT120	CLT.002.120	OCCURRENCE-CODE-END-DATE-09	Occurrence Code End Date 9
352	CLT121	CLT.002.121	OCCURRENCE-CODE-END-DATE-10	Occurrence Code End Date 10
353	CLT122	CLT.002.122	PATIENT-CONTROL-NUM	Patient Control Number

354	CLT123	CLT.002.123	ELIGIBLE-LAST-NAME	Eligible Last Name
355	CLT124	CLT.002.124	ELIGIBLE-FIRST-NAME	Eligible First Name
356	CLT125	CLT.002.125	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial
357	CLT126	CLT.002.126	DATE-OF-BIRTH	Date of Birth
358	CLT127	CLT.002.127	HEALTH-HOME-PROV-IND	Health Home Provider Indicator
359	CLT128	CLT.002.128	WAIVER-TYPE	Waiver Type
360	CLT129	CLT.002.129	WAIVER-ID	Waiver ID

361	CLT130	CLT.002.130	BILLING-PROV-NUM	Billing Provider Number
362	CLT131	CLT.002.131	BILLING-PROV-NPI-NUM	Billing Provider NPI Number
363	CLT132	CLT.002.132	BILLING-PROV-TAXONOMY	Billing Provider Taxonomy
364	CLT133	CLT.002.133	BILLING-PROV-TYPE	Billing Provider Type
365	CLT134	CLT.002.134	BILLING-PROV-SPECIALTY	Billing Provider Specialty
366	CLT135	CLT.002.135	REFERRING-PROV-NUM	Referring Provider Number
367	CLT136	CLT.002.136	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number

368	CLT140	CLT.002.140	MEDICARE-HIC-NUM	Medicare HIC Number
369	CLT141	CLT.002.141	PATIENT-STATUS	Patient Status
370	CLT144	CLT.002.144	REMITTANCE-NUM	Remittance Number
371	CLT145	CLT.002.145	LTC-RCP-LIAB-AMT	LTC RCP Liability Amount
372	CLT147	CLT.002.147	ICF-IID-DAYS	ICF IID Days
373	CLT148	CLT.002.148	LEAVE-DAYS	Leave Days

374	CLT149	CLT.002.149	NURSING-FACILITY-DAYS	Nursing Facility Days
375	CLT150	CLT.002.150	SPLIT-CLAIM-IND	Split Claim Indicator
376	CLT151	CLT.002.151	BORDER-STATE-IND	Border State Indicator
377	CLT153	CLT.002.153	TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT	Total Beneficiary Coinsurance Paid Amount
378	CLT154	CLT.002.154	BENEFICIARY-COINSURANCE-DATE-PAID	Beneficiary Coinsurance Date Paid
379	CLT155	CLT.002.155	TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT	Total Beneficiary Copayment Paid Amount
380	CLT156	CLT.002.156	BENEFICIARY-COPAYMENT-DATE-PAID	Beneficiary Copayment Date Paid
381	CLT157	CLT.002.157	TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT	Total Beneficiary Deductible Paid Amount
382	CLT158	CLT.002.158	BENEFICIARY-DEDUCTIBLE-DATE-PAID	Beneficiary Deductible Date Paid

383	CLT159	CLT.002.159	CLAIM-DENIED-INDICATOR	Claim Denied Indicator
384	CLT160	CLT.002.160	COPAY-WAIVED-IND	Copayment Waived Indicator
385	CLT161	CLT.002.161	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name
386	CLT163	CLT.002.163	THIRD-PARTY-COINSURANCE-AMOUNT-PAID	Third Party Coinsurance Amount Paid
387	CLT164	CLT.002.164	THIRD-PARTY-COINSURANCE-DATE-PAID	Third Party Coinsurance Date Paid
388	CLT165	CLT.002.165	THIRD-PARTY-COPAYMENT-AMOUNT-PAID	Third Party Copayment Amount Paid
389	CLT166	CLT.002.166	THIRD-PARTY-COPAYMENT-DATE-PAID	Third Party Copayment Date Paid
390	CLT167	CLT.002.167	HEALTH-HOME-PROVIDER-NPI	Health Home Provider NPI Number

391	CLT168	CLT.002.168	MEDICARE-BENEFICIARY-IDENTIFIER	Medicare Beneficiary Identifier
392	CLT174	CLT.002.174	ADMITTING-PROV-NPI-NUM	Admitting Provider NPI Number
393	CLT175	CLT.002.175	ADMITTING-PROV-NUM	Admitting Provider Number
394	CLT176	CLT.002.176	ADMITTING-PROV-SPECIALTY	Admitting Provider Specialty
395	CLT177	CLT.002.177	ADMITTING-PROV-TAXONOMY	Admitting Provider Taxonomy
396	CLT178	CLT.002.178	ADMITTING-PROV-TYPE	Admitting Provider Type
397	CLT179	CLT.002.179	MEDICARE-PAID-AMT	Medicare Paid Amount

398	CLT237	CLT.002.237	PROV-LOCATION-ID	Provider Location ID
399	CLT239	CLT.002.239	TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT	Total Beneficiary Copayment Liable Amount
400	CLT240	CLT.002.240	TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT	Total Beneficiary Coinsurance Liable Amount
401	CLT241	CLT.002.241	TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT	Total Beneficiary Deductible Liable Amount
402	CLT242	CLT.002.242	COMBINED-BENE-COST-SHARING-PAID-AMOUNT	Combined Beneficiary Cost Sharing Paid Amount
403	CLT244	CLT.002.244	BILLING-PROV-ADDR-LN-1	Billing Provider Address Line 1
404	CLT245	CLT.002.245	BILLING-PROV-ADDR-LN-2	Billing Provider Address Line 2
405	CLT246	CLT.002.246	BILLING-PROV-CITY	Billing Provider City
406	CLT247	CLT.002.247	BILLING-PROV-STATE	Billing Provider State Code

407	CLT248	CLT.002.248	BILLING-PROV-ZIP-CODE	Billing Provider ZIP Code
408	CLT249	CLT.002.249	SERVICE-FACILITY-LOCATION-ORG-NPI	Service Facility Location Organization NPI
409	CLT250	CLT.002.250	SERVICE-FACILITY-LOCATION-ADDR-LN-1	Service Facility Location Address Line 1
410	CLT251	CLT.002.251	SERVICE-FACILITY-LOCATION-ADDR-LN-2	Service Facility Location Address Line 2
411	CLT252	CLT.002.252	SERVICE-FACILITY-LOCATION-CITY	Service Facility Location City
412	CLT253	CLT.002.253	SERVICE-FACILITY-LOCATION-STATE	Service Facility Location State
413	CLT254	CLT.002.254	SERVICE-FACILITY-LOCATION-ZIP-CODE	Service Facility Location ZIP Code
414	CLT255	CLT.002.255	PROVIDER-CLAIM-FORM-CODE	Provider Claim Form Code
415	CLT256	CLT.002.256	PROVIDER-CLAIM-FORM-OTHER-TEXT	Provider Claim Form Other Text
416	CLT257	CLT.002.257	TOT-GME-AMOUNT-PAID	Total GME Amount Paid

417	CLT258	CLT.002.258	TOT-SDP-ALLOWED-AMT	Total State Directed Payment Allowed Amount
418	CLT259	CLT.002.259	TOT-SDP-PAID-AMT	Total State Directed Payment Paid Amount
419	CLT173	CLT.002.173	STATE-NOTATION	State Notation
420	CLT184	CLT.003.184	RECORD-ID	Record ID
421	CLT185	CLT.003.185	SUBMITTING-STATE	Submitting State
422	CLT186	CLT.003.186	RECORD-NUMBER	Record Number
423	CLT187	CLT.003.187	MSIS-IDENTIFICATION-NUM	MSIS Identification Number

424	CLT188	CLT.003.188	ICN-ORIG	Original ICN
425	CLT189	CLT.003.189	ICN-ADJ	Adjustment ICN
426	CLT190	CLT.003.190	LINE-NUM-ORIG	Original Line Number
427	CLT191	CLT.003.191	LINE-NUM-ADJ	Adjustment Line Number
428	CLT192	CLT.003.192	LINE-ADJUSTMENT-IND	Line Adjustment Indicator
429	CLT193	CLT.003.193	LINE-ADJUSTMENT-REASON-CODE	Line Adjustment Reason Code
430	CLT194	CLT.003.194	SUBMITTER-ID	Submitter ID
431	CLT195	CLT.003.195	CLAIM-LINE-STATUS	Claim Line Status

432	CLT196	CLT.003.196	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service
433	CLT197	CLT.003.197	ENDING-DATE-OF-SERVICE	Ending Date of Service
434	CLT198	CLT.003.198	REVENUE-CODE	Revenue Code
435	CLT202	CLT.003.202	REVENUE-CENTER-QUANTITY-ACTUAL	Revenue Center Quantity Actual

436	CLT203	CLT.003.203	REVENUE-CENTER-QUANTITY-ALLOWED	Revenue Center Quantity Allowed
437	CLT204	CLT.003.204	REVENUE-CHARGE	Revenue Charge
438	CLT205	CLT.003.205	ALLOWED-AMT	Allowed Amount
439	CLT206	CLT.003.206	TPL-AMT	TPL Amount

440	CLT207	CLT.003.207	OTHER-INSURANCE-AMT	Other Insurance Amount
441	CLT208	CLT.003.208	MEDICAID-PAID-AMT	Medicaid Paid Amount
442	CLT209	CLT.003.209	MEDICAID-FFS-EQUIVALENT-AMT	Medicaid FFS Equivalent Amount
443	CLT210	CLT.003.210	BILLING-UNIT	Billing Unit
444	CLT211	CLT.003.211	TYPE-OF-SERVICE	Type of Service
445	CLT212	CLT.003.212	SERVICING-PROV-NUM	Servicing Provider Number
446	CLT213	CLT.003.213	SERVICING-PROV-NPI-NUM	Servicing Provider NPI Number
447	CLT215	CLT.003.215	SERVICING-PROV-TYPE	Servicing Provider Type

448	CLT216	CLT.003.216	SERVICING-PROV-SPECIALTY	Servicing Provider Specialty
449	CLT217	CLT.003.217	OTHER-TPL-COLLECTION	Other TPL Collection
450	CLT219	CLT.003.219	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
451	CLT221	CLT.003.221	PROV-FACILITY-TYPE	Provider Facility Type
452	CLT228	CLT.003.228	NATIONAL-DRUG-CODE	National Drug Code
453	CLT229	CLT.003.229	NDC-UNIT-OF-MEASURE	NDC Unit of Measure
454	CLT230	CLT.003.230	NDC-QUANTITY	NDC Quantity
455	CLT233	CLT.003.233	ADJUDICATION-DATE	Adjudication Date
456	CLT234	CLT.003.234	SELF-DIRECTION-TYPE	Self Direction Type
457	CLT235	CLT.003.235	PRE-AUTHORIZATION-NUM	Preauthorization Number
458	CLT243	CLT.003.243	IHS-SERVICE-IND	IHS Service Indicator

459	CLT260	CLT.003.260	UNIQUE-DEVICE-IDENTIFIER	Unique Device Identifier
460	CLT282	CLT.003.282	MBESCBES-FORM-GROUP	MBESCBES Form Group
461	CLT262	CLT.003.262	MBESCBES-FORM	MBESCBES Form
462	CLT261	CLT.003.261	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service
463	CLT263	CLT.003.263	GME-AMOUNT-PAID	GME Amount Paid

464	CLT264	CLT.003.264	REFERRING-PROV-NUM	Referring Provider Number
465	CLT265	CLT.003.265	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number
466	CLT266	CLT.003.266	SDP-ALLOWED-AMT	State Directed Payment Allowed Amount
467	CLT267	CLT.003.267	SDP-PAID-AMT	State Directed Payment Paid Amount
468	CLT226	CLT.003.226	STATE-NOTATION	State Notation
469	CLT268	CLT.004.268	RECORD-ID	Record ID
470	CLT269	CLT.004.269	SUBMITTING-STATE	Submitting State
471	CLT270	CLT.004.270	RECORD-NUMBER	Record Number
472	CLT271	CLT.004.271	ICN-ORIG	Original ICN

473	CLT272	CLT.004.272	ICN-ADJ	Adjustment ICN
474	CLT273	CLT.004.273	ADJUSTMENT-IND	Adjustment Indicator
475	CLT274	CLT.004.274	ADJUDICATION-DATE	Adjudication Date
476	CLT275	CLT.004.275	DIAGNOSIS-TYPE	Diagnosis Type
477	CLT276	CLT.004.276	DIAGNOSIS-SEQUENCE-NUMBER	Diagnosis Sequence Number
478	CLT277	CLT.004.277	DIAGNOSIS-CODE-FLAG	Diagnosis Code Flag
479	CLT278	CLT.004.278	DIAGNOSIS-CODE	Diagnosis Code

480	CLT279	CLT.004.279	DIAGNOSIS-POA-FLAG	Diagnosis POA Flag
481	CLT280	CLT.004.280	STATE-NOTATION	State Notation
482	COT001	COT.001.001	RECORD-ID	Record ID
483	COT002	COT.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version
484	COT003	COT.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type
485	COT004	COT.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification
486	COT005	COT.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version
487	COT006	COT.001.006	FILE-NAME	File Name
488	COT007	COT.001.007	SUBMITTING-STATE	Submitting State

489	COT008	COT.001.008	DATE-FILE-CREATED	Date File Created
490	COT009	COT.001.009	START-OF-TIME-PERIOD	Start of Time Period
491	COT010	COT.001.010	END-OF-TIME-PERIOD	End of Time Period
492	COT011	COT.001.011	FILE-STATUS-INDICATOR	File Status Indicator
493	COT012	COT.001.012	SSN-INDICATOR	SSN Indicator
494	COT013	COT.001.013	TOT-REC-CNT	Total Record Count
495	COT216	COT.001.216	SEQUENCE-NUMBER	Sequence Number
496	COT014	COT.001.014	STATE-NOTATION	State Notation

497	COT016	COT.002.016	RECORD-ID	Record ID
498	COT017	COT.002.017	SUBMITTING-STATE	Submitting State
499	COT018	COT.002.018	RECORD-NUMBER	Record Number
500	COT019	COT.002.019	ICN-ORIG	Original ICN
501	COT020	COT.002.020	ICN-ADJ	Adjustment ICN
502	COT021	COT.002.021	SUBMITTER-ID	Submitter ID
503	COT022	COT.002.022	MSIS-IDENTIFICATION-NUM	MSIS Identification Number

504	COT023	COT.002.023	CROSSOVER-INDICATOR	Crossover Indicator
505	COT024	COT.002.024	1115A-DEMONSTRATION-IND	1115A Demonstration Indicator
506	COT025	COT.002.025	ADJUSTMENT-IND	Adjustment Indicator
507	COT026	COT.002.026	ADJUSTMENT-REASON-CODE	Adjustment Reason Code
508	COT033	COT.002.033	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service

509	COT034	COT.002.034	ENDING-DATE-OF-SERVICE	Ending Date of Service
510	COT035	COT.002.035	ADJUDICATION-DATE	Adjudication Date
511	COT036	COT.002.036	MEDICAID-PAID-DATE	Medicaid Paid Date
512	COT037	COT.002.037	TYPE-OF-CLAIM	Type of Claim
513	COT038	COT.002.038	TYPE-OF-BILL	Type of Bill
514	COT039	COT.002.039	CLAIM-STATUS	Claim Status
515	COT040	COT.002.040	CLAIM-STATUS-CATEGORY	Claim Status Category

516	COT041	COT.002.041	SOURCE-LOCATION	Source Location
517	COT042	COT.002.042	CHECK-NUM	Check Number
518	COT043	COT.002.043	CHECK-EFF-DATE	Check Effective Date
519	COT044	COT.002.044	CLAIM-PYMT-REM-CODE-1	Remittance Advice Remark Code 1
520	COT045	COT.002.045	CLAIM-PYMT-REM-CODE-2	Remittance Advice Remark Code 2

521	COT046	COT.002.046	CLAIM-PYMT-REM-CODE-3	Remittance Advice Remark Code 3
522	COT047	COT.002.047	CLAIM-PYMT-REM-CODE-4	Remittance Advice Remark Code 4
523	COT048	COT.002.048	TOT-BILLED-AMT	Total Billed Amount
524	COT049	COT.002.049	TOT-ALLOWED-AMT	Total Allowed Amount

525	COT050	COT.002.050	TOT-MEDICAID-PAID-AMT	Total Medicaid Paid Amount
526	COT052	COT.002.052	TOT-MEDICARE-DEDUCTIBLE-AMT	Total Medicare Deductible Amount
527	COT053	COT.002.053	TOT-MEDICARE-COINS-AMT	Total Medicare Coinsurance Amount
528	COT054	COT.002.054	TOT-TPL-AMT	Total TPL Amount

529	COT056	COT.002.056	TOT-OTHER-INSURANCE-AMT	Total Other Insurance Amount
530	COT057	COT.002.057	OTHER-INSURANCE-IND	Other Insurance Indicator
531	COT058	COT.002.058	OTHER-TPL-COLLECTION	Other TPL Collection
532	COT061	COT.002.061	FIXED-PAYMENT-IND	Fixed Payment Indicator
533	COT062	COT.002.062	FUNDING-CODE	Funding Code
534	COT063	COT.002.063	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Non-Federal Share
535	COT064	COT.002.064	MEDICARE-COMB-DED-IND	Medicare Combined Deductible Indicator

536	COT065	COT.002.065	PROGRAM-TYPE	Program Type
537	COT066	COT.002.066	PLAN-ID-NUMBER	Plan ID Number

538	COT068	COT.002.068	PAYMENT-LEVEL-IND	Payment Level Indicator
539	COT069	COT.002.069	MEDICARE-REIM-TYPE	Medicare Reimbursement Type
540	COT070	COT.002.070	CLAIM-LINE-COUNT	Claim Line Count
541	COT072	COT.002.072	FORCED-CLAIM-IND	Forced Claim Indicator

542	COT073	COT.002.073	HEALTH-CARE-ACQUIRED-CONDITION-IND	Healthcare Acquired Condition Indicator
543	COT074	COT.002.074	OCCURRENCE-CODE-01	Occurrence Code 1
544	COT075	COT.002.075	OCCURRENCE-CODE-02	Occurrence Code 2
545	COT076	COT.002.076	OCCURRENCE-CODE-03	Occurrence Code 3
546	COT077	COT.002.077	OCCURRENCE-CODE-04	Occurrence Code 4
547	COT078	COT.002.078	OCCURRENCE-CODE-05	Occurrence Code 5
548	COT079	COT.002.079	OCCURRENCE-CODE-06	Occurrence Code 6
549	COT080	COT.002.080	OCCURRENCE-CODE-07	Occurrence Code 7
550	COT081	COT.002.081	OCCURRENCE-CODE-08	Occurrence Code 8
551	COT082	COT.002.082	OCCURRENCE-CODE-09	Occurrence Code 9
552	COT083	COT.002.083	OCCURRENCE-CODE-10	Occurrence Code 10

553	COT084	COT.002.084	OCCURRENCE-CODE-EFF-DATE-01	Occurrence Code Effective Date 1
554	COT085	COT.002.085	OCCURRENCE-CODE-EFF-DATE-02	Occurrence Code Effective Date 2
555	COT086	COT.002.086	OCCURRENCE-CODE-EFF-DATE-03	Occurrence Code Effective Date 3
556	COT087	COT.002.087	OCCURRENCE-CODE-EFF-DATE-04	Occurrence Code Effective Date 4
557	COT088	COT.002.088	OCCURRENCE-CODE-EFF-DATE-05	Occurrence Code Effective Date 5
558	COT089	COT.002.089	OCCURRENCE-CODE-EFF-DATE-06	Occurrence Code Effective Date 6
559	COT090	COT.002.090	OCCURRENCE-CODE-EFF-DATE-07	Occurrence Code Effective Date 7
560	COT091	COT.002.091	OCCURRENCE-CODE-EFF-DATE-08	Occurrence Code Effective Date 8
561	COT092	COT.002.092	OCCURRENCE-CODE-EFF-DATE-09	Occurrence Code Effective Date 9

562	COT093	COT.002.093	OCCURRENCE-CODE-EFF-DATE-10	Occurrence Code Effective Date 10
563	COT094	COT.002.094	OCCURRENCE-CODE-END-DATE-01	Occurrence Code End Date 1
564	COT095	COT.002.095	OCCURRENCE-CODE-END-DATE-02	Occurrence Code End Date 2
565	COT096	COT.002.096	OCCURRENCE-CODE-END-DATE-03	Occurrence Code End Date 3
566	COT097	COT.002.097	OCCURRENCE-CODE-END-DATE-04	Occurrence Code End Date 4
567	COT098	COT.002.098	OCCURRENCE-CODE-END-DATE-05	Occurrence Code End Date 5
568	COT099	COT.002.099	OCCURRENCE-CODE-END-DATE-06	Occurrence Code End Date 6
569	COT100	COT.002.100	OCCURRENCE-CODE-END-DATE-07	Occurrence Code End Date 7
570	COT101	COT.002.101	OCCURRENCE-CODE-END-DATE-08	Occurrence Code End Date 8
571	COT102	COT.002.102	OCCURRENCE-CODE-END-DATE-09	Occurrence Code End Date 9
572	COT103	COT.002.103	OCCURRENCE-CODE-END-DATE-10	Occurrence Code End Date 10

573	COT104	COT.002.104	PATIENT-CONTROL-NUM	Patient Control Number
574	COT105	COT.002.105	ELIGIBLE-LAST-NAME	Eligible Last Name
575	COT106	COT.002.106	ELIGIBLE-FIRST-NAME	Eligible First Name
576	COT107	COT.002.107	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial
577	COT108	COT.002.108	DATE-OF-BIRTH	Date of Birth
578	COT109	COT.002.109	HEALTH-HOME-PROV-IND	Health Home Provider Indicator
579	COT110	COT.002.110	WAIVER-TYPE	Waiver Type
580	COT111	COT.002.111	WAIVER-ID	Waiver ID

581	COT112	COT.002.112	BILLING-PROV-NUM	Billing Provider Number
582	COT113	COT.002.113	BILLING-PROV-NPI-NUM	Billing Provider NPI Number
583	COT114	COT.002.114	BILLING-PROV-TAXONOMY	Billing Provider Taxonomy
584	COT115	COT.002.115	BILLING-PROV-TYPE	Billing Provider Type
585	COT116	COT.002.116	BILLING-PROV-SPECIALTY	Billing Provider Specialty
586	COT117	COT.002.117	REFERRING-PROV-NUM	Referring Provider Number
587	COT118	COT.002.118	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number

588	COT122	COT.002.122	MEDICARE-HIC-NUM	Medicare HIC Number
589	COT123	COT.002.123	PLACE-OF-SERVICE	Place of Service
590	COT126	COT.002.126	REMITTANCE-NUM	Remittance Number
591	COT127	COT.002.127	DAILY-RATE	Daily Rate
592	COT128	COT.002.128	BORDER-STATE-IND	Border State Indicator
593	COT130	COT.002.130	TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT	Total Beneficiary Coinsurance Paid Amount
594	COT131	COT.002.131	BENEFICIARY-COINSURANCE-DATE-PAID	Beneficiary Coinsurance Date Paid
595	COT132	COT.002.132	TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT	Total Beneficiary Copayment Paid Amount
596	COT133	COT.002.133	BENEFICIARY-COPAYMENT-DATE-PAID	Beneficiary Copayment Date Paid
597	COT134	COT.002.134	TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT	Total Beneficiary Deductible Paid Amount

598	COT135	COT.002.135	BENEFICIARY-DEDUCTIBLE-DATE-PAID	Beneficiary Deductible Date Paid
599	COT136	COT.002.136	CLAIM-DENIED-INDICATOR	Claim Denied Indicator
600	COT137	COT.002.137	COPAY-WAIVED-IND	Copayment Waived Indicator
601	COT138	COT.002.138	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name
602	COT140	COT.002.140	THIRD-PARTY-COINSURANCE-AMOUNT-PAID	Third Party Coinsurance Amount Paid
603	COT141	COT.002.141	THIRD-PARTY-COINSURANCE-DATE-PAID	Third Party Coinsurance Date Paid
604	COT142	COT.002.142	THIRD-PARTY-COPAYMENT-AMOUNT-PAID	Third Party Copayment Amount Paid
605	COT143	COT.002.143	THIRD-PARTY-COPAYMENT-DATE-PAID	Third Party Copayment Date Paid
606	COT146	COT.002.146	HEALTH-HOME-PROVIDER-NPI	Health Home Provider NPI Number

607	COT147	COT.002.147	MEDICARE-BENEFICIARY-IDENTIFIER	Medicare Beneficiary Identifier
608	COT226	COT.002.226	PROV-LOCATION-ID	Provider Location ID
609	COT230	COT.002.230	TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT	Total Beneficiary Copayment Liable Amount
610	COT231	COT.002.231	TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT	Total Beneficiary Coinsurance Liable Amount
611	COT232	COT.002.232	TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT	Total Beneficiary Deductible Liable Amount

612	COT233	COT.002.233	COMBINED-BENE-COST-SHARING-PAID-AMOUNT	Combined Beneficiary Cost Sharing Paid Amount
613	COT235	COT.002.235	LTC-RCP-LIAB-AMT	LTC RCP Liability Amount
614	COT236	COT.002.236	BILLING-PROV-ADDR-LN-1	Billing Provider Address Line 1
615	COT237	COT.002.237	BILLING-PROV-ADDR-LN-2	Billing Provider Address Line 2
616	COT238	COT.002.238	BILLING-PROV-CITY	Billing Provider City
617	COT239	COT.002.239	BILLING-PROV-STATE	Billing Provider State Code
618	COT240	COT.002.240	BILLING-PROV-ZIP-CODE	Billing Provider ZIP Code
619	COT241	COT.002.241	SERVICE-FACILITY-LOCATION-ORG-NPI	Service Facility Location Organization NPI
620	COT242	COT.002.242	SERVICE-FACILITY-LOCATION-ADDR-LN-1	Service Facility Location Address Line 1

621	COT243	COT.002.243	SERVICE-FACILITY-LOCATION-ADDR-LN-2	Service Facility Location Address Line 2
622	COT244	COT.002.244	SERVICE-FACILITY-LOCATION-CITY	Service Facility Location City
623	COT245	COT.002.245	SERVICE-FACILITY-LOCATION-STATE	Service Facility Location State
624	COT246	COT.002.246	SERVICE-FACILITY-LOCATION-ZIP-CODE	Service Facility Location ZIP Code
625	COT247	COT.002.247	PROVIDER-CLAIM-FORM-CODE	Provider Claim Form Code
626	COT248	COT.002.248	PROVIDER-CLAIM-FORM-OTHER-TEXT	Provider Claim Form Other Text
627	COT249	COT.002.249	TOT-GME-AMOUNT-PAID	Total GME Amount Paid
628	COT250	COT.002.250	REFERRING-PROV-NUM-2	Referring Provider Number 2
629	COT251	COT.002.251	REFERRING-PROV-NPI-NUM-2	Referring Provider NPI Number 2

630	COT252	COT.002.252	TOT-SDP-ALLOWED-AMT	Total State Directed Payment Allowed Amount
631	COT253	COT.002.253	TOT-SDP-PAID-AMT	Total State Directed Payment Paid Amount
632	COT152	COT.002.152	STATE-NOTATION	State Notation
633	COT154	COT.003.154	RECORD-ID	Record ID
634	COT155	COT.003.155	SUBMITTING-STATE	Submitting State
635	COT156	COT.003.156	RECORD-NUMBER	Record Number
636	COT157	COT.003.157	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
637	COT158	COT.003.158	ICN-ORIG	Original ICN

638	COT159	COT.003.159	ICN-ADJ	Adjustment ICN
639	COT160	COT.003.160	LINE-NUM-ORIG	Original Line Number
640	COT161	COT.003.161	LINE-NUM-ADJ	Adjustment Line Number
641	COT162	COT.003.162	LINE-ADJUSTMENT-IND	Line Adjustment Indicator
642	COT163	COT.003.163	LINE-ADJUSTMENT-REASON-CODE	Line Adjustment Reason Code
643	COT164	COT.003.164	SUBMITTER-ID	Submitter ID
644	COT165	COT.003.165	CLAIM-LINE-STATUS	Claim Line Status

645	COT166	COT.003.166	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service
646	COT167	COT.003.167	ENDING-DATE-OF-SERVICE	Ending Date of Service
647	COT168	COT.003.168	REVENUE-CODE	Revenue Code
648	COT169	COT.003.169	PROCEDURE-CODE	Procedure Code

649	COT170	COT.003.170	PROCEDURE-CODE-DATE	Procedure Code Date
650	COT171	COT.003.171	PROCEDURE-CODE-FLAG	Procedure Code Flag
651	COT172	COT.003.172	PROCEDURE-CODE-MOD-1	Procedure Code Modifier 1
652	COT174	COT.003.174	BILLED-AMT	Billed Amount
653	COT175	COT.003.175	ALLOWED-AMT	Allowed Amount

654	COT176	COT.003.176	BENEFICIARY-COPAYMENT-PAID-AMOUNT	Beneficiary Copayment Paid Amount
655	COT177	COT.003.177	TPL-AMT	TPL Amount
656	COT178	COT.003.178	MEDICAID-PAID-AMT	Medicaid Paid Amount
657	COT179	COT.003.179	MEDICAID-FFS-EQUIVALENT-AMT	Medicaid FFS Equivalent Amount
658	COT182	COT.003.182	MEDICARE-PAID-AMT	Medicare Paid Amount
659	COT183	COT.003.183	SERVICE-QUANTITY-ACTUAL	Service Quantity Actual

660	COT184	COT.003.184	SERVICE-QUANTITY-ALLOWED	Service Quantity Allowed
661	COT186	COT.003.186	TYPE-OF-SERVICE	Type of Service
662	COT187	COT.003.187	HCBS-SERVICE-CODE	HCBS Service Code

663	COT188	COT.003.188	HCBS-TAXONOMY	HCBS Taxonomy
664	COT189	COT.003.189	SERVICING-PROV-NUM	Servicing Provider Number
665	COT190	COT.003.190	SERVICING-PROV-NPI-NUM	Servicing Provider NPI Number
666	COT191	COT.003.191	SERVICING-PROV-TAXONOMY	Servicing Provider Taxonomy

667	COT192	COT.003.192	SERVICING-PROV-TYPE	Servicing Provider Type
668	COT193	COT.003.193	SERVICING-PROV-SPECIALTY	Servicing Provider Specialty
669	COT194	COT.003.194	OTHER-TPL-COLLECTION	Other TPL Collection
670	COT195	COT.003.195	TOOTH-DESIGNATION-SYSTEM	Tooth Designation System
671	COT196	COT.003.196	TOOTH-NUM	Tooth Number
672	COT197	COT.003.197	TOOTH-QUAD-CODE	Tooth Quad Code
673	COT198	COT.003.198	TOOTH-SURFACE-CODE	Tooth Surface Code
674	COT199	COT.003.199	ORIGINATION-ADDR-LN1	Origination Address Line 1

675	COT200	COT.003.200	ORIGINATION-ADDR-LN2	Origination Address Line 2
676	COT201	COT.003.201	ORIGINATION-CITY	Origination City
677	COT202	COT.003.202	ORIGINATION-STATE	Origination State
678	COT203	COT.003.203	ORIGINATION-ZIP-CODE	Origination ZIP Code
679	COT204	COT.003.204	DESTINATION-ADDR-LN1	Destination Address Line 1
680	COT205	COT.003.205	DESTINATION-ADDR-LN2	Destination Address Line 2
681	COT206	COT.003.206	DESTINATION-CITY	Destination City
682	COT207	COT.003.207	DESTINATION-STATE	Destination State
683	COT208	COT.003.208	DESTINATION-ZIP-CODE	Destination ZIP Code

684	COT210	COT.003.210	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
685	COT213	COT.003.213	OTHER-INSURANCE-AMT	Other Insurance Amount
686	COT217	COT.003.217	NATIONAL-DRUG-CODE	National Drug Code
687	COT227	COT.003.227	PROCEDURE-CODE-MOD-2	Procedure Code Modifier 2
688	COT218	COT.003.218	PROCEDURE-CODE-MOD-3	Procedure Code Modifier 3
689	COT219	COT.003.219	PROCEDURE-CODE-MOD-4	Procedure Code Modifier 4
690	COT221	COT.003.221	ADJUDICATION-DATE	Adjudication Date
691	COT222	COT.003.222	SELF-DIRECTION-TYPE	Self Direction Type
692	COT223	COT.003.223	PRE-AUTHORIZATION-NUM	Preauthorization Number

693	COT224	COT.003.224	NDC-UNIT-OF-MEASURE	NDC Unit of Measure
694	COT225	COT.003.225	NDC-QUANTITY	NDC Quantity
695	COT234	COT.003.234	IHS-SERVICE-IND	IHS Service Indicator
696	COT254	COT.003.254	DIAGNOSIS-CODE-POINTER-1	Diagnosis Code Pointer 1
697	COT287	COT.003.287	DIAGNOSIS-CODE-POINTER-2	Diagnosis Code Pointer 2
698	COT288	COT.003.288	DIAGNOSIS-CODE-POINTER-3	Diagnosis Code Pointer 3
699	COT289	COT.003.289	DIAGNOSIS-CODE-POINTER-4	Diagnosis Code Pointer 4
700	COT255	COT.003.255	UNIQUE-DEVICE-IDENTIFIER	Unique Device Identifier
701	COT290	COT.003.290	MBESCBES-FORM-GROUP	MBESCBES Form Group
702	COT257	COT.003.257	MBESCBES-FORM	MBESCBES Form

703	COT256	COT.003.256	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service
704	COT258	COT.003.258	SERVICE-FACILITY-LOCATION-ORG-NPI	Service Facility Location Organization NPI
705	COT259	COT.003.259	SERVICE-FACILITY-LOCATION-ADDR-LN-1	Service Facility Location Address Line 1
706	COT260	COT.003.260	SERVICE-FACILITY-LOCATION-ADDR-LN-2	Service Facility Location Address Line 2
707	COT261	COT.003.261	SERVICE-FACILITY-LOCATION-CITY	Service Facility Location City

708	COT262	COT.003.262	SERVICE-FACILITY-LOCATION-STATE	Service Facility Location State
709	COT263	COT.003.263	SERVICE-FACILITY-LOCATION-ZIP-CODE	Service Facility Location ZIP Code
710	COT264	COT.003.264	PLACE-OF-SERVICE	Place of Service
711	COT265	COT.003.265	GME-AMOUNT-PAID	GME Amount Paid
712	COT266	COT.003.266	REFERRING-PROV-NUM	Referring Provider Number
713	COT267	COT.003.267	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number
714	COT268	COT.003.268	REFERRING-PROV-NUM-2	Referring Provider Number 2

715	COT269	COT.003.269	REFERRING-PROV-NPI-NUM-2	Referring Provider NPI Number 2
716	COT270	COT.003.270	ORDERING-PROV-NUM	Ordering Provider Number
717	COT271	COT.003.271	ORDERING-PROV-NPI-NUM	order Provider NPI Number
718	COT272	COT.003.272	SDP-ALLOWED-AMT	State Directed Payment Allowed Amount
719	COT273	COT.003.273	SDP-PAID-AMT	State Directed Payment Paid Amount
720	COT214	COT.003.214	STATE-NOTATION	State Notation
721	COT274	COT.004.274	RECORD-ID	Record ID
722	COT275	COT.004.275	SUBMITTING-STATE	Submitting State
723	COT276	COT.004.276	RECORD-NUMBER	Record Number

724	COT277	COT.004.277	ICN-ORIG	Original ICN
725	COT278	COT.004.278	ICN-ADJ	Adjustment ICN
726	COT279	COT.004.279	ADJUSTMENT-IND	Adjustment Indicator
727	COT280	COT.004.280	ADJUDICATION-DATE	Adjudication Date
728	COT281	COT.004.281	DIAGNOSIS-TYPE	Diagnosis Type
729	COT282	COT.004.282	DIAGNOSIS-SEQUENCE-NUMBER	Diagnosis Sequence Number
730	COT283	COT.004.283	DIAGNOSIS-CODE-FLAG	Diagnosis Code Flag

731	COT284	COT.004.284	DIAGNOSIS-CODE	Diagnosis Code
732	COT285	COT.004.285	STATE-NOTATION	State Notation
733	CRX001	CRX.001.001	RECORD-ID	Record ID
734	CRX002	CRX.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version
735	CRX003	CRX.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type
736	CRX004	CRX.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification
737	CRX005	CRX.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version
738	CRX006	CRX.001.006	FILE-NAME	File Name
739	CRX007	CRX.001.007	SUBMITTING-STATE	Submitting State
740	CRX008	CRX.001.008	DATE-FILE-CREATED	Date File Created

741	CRX009	CRX.001.009	START-OF-TIME-PERIOD	Start of Time Period
742	CRX010	CRX.001.010	END-OF-TIME-PERIOD	End of Time Period
743	CRX011	CRX.001.011	FILE-STATUS-INDICATOR	File Status Indicator
744	CRX012	CRX.001.012	SSN-INDICATOR	SSN Indicator
745	CRX013	CRX.001.013	TOT-REC-CNT	Total Record Count
746	CRX155	CRX.001.155	SEQUENCE-NUMBER	Sequence Number
747	CRX014	CRX.001.014	STATE-NOTATION	State Notation
748	CRX016	CRX.002.016	RECORD-ID	Record ID

749	CRX017	CRX.002.017	SUBMITTING-STATE	Submitting State
750	CRX018	CRX.002.018	RECORD-NUMBER	Record Number
751	CRX019	CRX.002.019	ICN-ORIG	Original ICN
752	CRX020	CRX.002.020	ICN-ADJ	Adjustment ICN
753	CRX021	CRX.002.021	SUBMITTER-ID	Submitter ID
754	CRX022	CRX.002.022	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
755	CRX023	CRX.002.023	CROSSOVER-INDICATOR	Crossover Indicator

756	CRX024	CRX.002.024	1115A-DEMONSTRATION-IND	1115A Demonstration Indicator
757	CRX025	CRX.002.025	ADJUSTMENT-IND	Adjustment Indicator
758	CRX026	CRX.002.026	ADJUSTMENT-REASON-CODE	Adjustment Reason Code
759	CRX027	CRX.002.027	ADJUDICATION-DATE	Adjudication Date
760	CRX028	CRX.002.028	MEDICAID-PAID-DATE	Medicaid Paid Date
761	CRX029	CRX.002.029	TYPE-OF-CLAIM	Type of Claim
762	CRX030	CRX.002.030	CLAIM-STATUS	Claim Status
763	CRX031	CRX.002.031	CLAIM-STATUS-CATEGORY	Claim Status Category

764	CRX032	CRX.002.032	SOURCE-LOCATION	Source Location
765	CRX033	CRX.002.033	CHECK-NUM	Check Number
766	CRX034	CRX.002.034	CHECK-EFF-DATE	Check Effective Date
767	CRX035	CRX.002.035	CLAIM-PYMT-REM-CODE-1	Remittance Advice Remark Code 1
768	CRX036	CRX.002.036	CLAIM-PYMT-REM-CODE-2	Remittance Advice Remark Code 2

769	CRX037	CRX.002.037	CLAIM-PYMT-REM-CODE-3	Remittance Advice Remark Code 3
770	CRX038	CRX.002.038	CLAIM-PYMT-REM-CODE-4	Remittance Advice Remark Code 4
771	CRX039	CRX.002.039	TOT-BILLED-AMT	Total Billed Amount
772	CRX040	CRX.002.040	TOT-ALLOWED-AMT	Total Allowed Amount

773	CRX041	CRX.002.041	TOT-MEDICAID-PAID-AMT	Total Medicaid Paid Amount
774	CRX043	CRX.002.043	TOT-MEDICARE-DEDUCTIBLE-AMT	Total Medicare Deductible Amount
775	CRX044	CRX.002.044	TOT-MEDICARE-COINS-AMT	Total Medicare Coinsurance Amount
776	CRX045	CRX.002.045	TOT-TPL-AMT	Total TPL Amount

777	CRX047	CRX.002.047	TOT-OTHER-INSURANCE-AMT	Total Other Insurance Amount
778	CRX048	CRX.002.048	OTHER-INSURANCE-IND	Other Insurance Indicator
779	CRX049	CRX.002.049	OTHER-TPL-COLLECTION	Other TPL Collection
780	CRX052	CRX.002.052	FIXED-PAYMENT-IND	Fixed Payment Indicator
781	CRX053	CRX.002.053	FUNDING-CODE	Funding Code
782	CRX054	CRX.002.054	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Non-Federal Share
783	CRX055	CRX.002.055	PROGRAM-TYPE	Program Type

784	CRX056	CRX.002.056	PLAN-ID-NUMBER	Plan ID Number
785	CRX058	CRX.002.058	PAYMENT-LEVEL-IND	Payment Level Indicator

786	CRX059	CRX.002.059	MEDICARE-REIM-TYPE	Medicare Reimbursement Type
787	CRX060	CRX.002.060	CLAIM-LINE-COUNT	Claim Line Count
788	CRX061	CRX.002.061	FORCED-CLAIM-IND	Forced Claim Indicator
789	CRX062	CRX.002.062	PATIENT-CONTROL-NUM	Patient Control Number
790	CRX063	CRX.002.063	ELIGIBLE-LAST-NAME	Eligible Last Name
791	CRX064	CRX.002.064	ELIGIBLE-FIRST-NAME	Eligible First Name
792	CRX065	CRX.002.065	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial
793	CRX066	CRX.002.066	DATE-OF-BIRTH	Date of Birth
794	CRX067	CRX.002.067	HEALTH-HOME-PROV-IND	Health Home Provider Indicator

795	CRX068	CRX.002.068	WAIVER-TYPE	Waiver Type
796	CRX069	CRX.002.069	WAIVER-ID	Waiver ID
797	CRX070	CRX.002.070	BILLING-PROV-NUM	Billing Provider Number
798	CRX071	CRX.002.071	BILLING-PROV-NPI-NUM	Billing Provider NPI Number
799	CRX072	CRX.002.072	BILLING-PROV-TAXONOMY	Billing Provider Taxonomy

800	CRX073	CRX.002.073	BILLING-PROV-SPECIALTY	Billing Provider Specialty
801	CRX074	CRX.002.074	PRESCRIBING-PROV-NUM	Prescribing Provider Number
802	CRX075	CRX.002.075	PRESCRIBING-PROV-NPI-NUM	Prescribing Provider NPI Number
803	CRX079	CRX.002.079	MEDICARE-HIC-NUM	Medicare HIC Number
804	CRX081	CRX.002.081	REMITTANCE-NUM	Remittance Number
805	CRX082	CRX.002.082	BORDER-STATE-IND	Border State Indicator
806	CRX084	CRX.002.084	DATE-PRESCRIBED	Date Prescribed

807	CRX085	CRX.002.085	PRESCRIPTION-FILL-DATE	Prescription Fill Date
808	CRX086	CRX.002.086	COMPOUND-DRUG-IND	Compound Drug Indicator
809	CRX087	CRX.002.087	TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT	Total Beneficiary Coinsurance Paid Amount
810	CRX088	CRX.002.088	BENEFICIARY-COINSURANCE-DATE-PAID	Beneficiary Coinsurance Date Paid
811	CRX089	CRX.002.089	TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT	Total Beneficiary Copayment Paid Amount
812	CRX090	CRX.002.090	BENEFICIARY-COPAYMENT-DATE-PAID	Beneficiary Copayment Date Paid
813	CRX092	CRX.002.092	TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT	Total Beneficiary Deductible Paid Amount
814	CRX093	CRX.002.093	BENEFICIARY-DEDUCTIBLE-DATE-PAID	Beneficiary Deductible Date Paid
815	CRX094	CRX.002.094	CLAIM-DENIED-INDICATOR	Claim Denied Indicator

816	CRX095	CRX.002.095	COPAY-WAIVED-IND	Copayment Waived Indicator
817	CRX096	CRX.002.096	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name
818	CRX098	CRX.002.098	THIRD-PARTY-COINSURANCE-AMOUNT-PAID	Third Party Coinsurance Amount Paid
819	CRX099	CRX.002.099	THIRD-PARTY-COINSURANCE-DATE-PAID	Third Party Coinsurance Date Paid
820	CRX100	CRX.002.100	THIRD-PARTY-COPAYMENT-AMOUNT-PAID	Third Party Copayment Amount Paid
821	CRX101	CRX.002.101	THIRD-PARTY-COPAYMENT-DATE-PAID	Third Party Copayment Date Paid
822	CRX102	CRX.002.102	DISPENSING-PRESCRIPTION-DRUG-PROV-NPI	Dispensing Prescription Drug Provider NPI Number
823	CRX104	CRX.002.104	HEALTH-HOME-PROVIDER-NPI	Health Home Provider NPI Number

824	CRX105	CRX.002.105	MEDICARE-BENEFICIARY-IDENTIFIER	Medicare Beneficiary Identifier
825	CRX156	CRX.002.156	DISPENSING-PRESCRIPTION-DRUG-PROV-NUM	Dispensing Prescription Drug Provider Number
826	CRX160	CRX.002.160	MEDICARE-COMB-DED-IND	Medicare Combined Deductible Indicator
827	CRX161	CRX.002.161	PROV-LOCATION-ID	Provider Location ID
828	CRX162	CRX.002.162	PRESCRIPTION-ORIGIN-CODE	Prescription Origin Code

829	CRX163	CRX.002.163	TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT	Total Beneficiary Copayment Liable Amount
830	CRX164	CRX.002.164	TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT	Total Beneficiary Coinsurance Liable Amount
831	CRX165	CRX.002.165	TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT	Total Beneficiary Deductible Liable Amount
832	CRX166	CRX.002.166	COMBINED-BENE-COST-SHARING-PAID-AMOUNT	Combined Beneficiary Cost Sharing Paid Amount
833	CRX173	CRX.002.173	LTC-RCP-LIAB-AMT	LTC RCP Liability Amount
834	CRX174	CRX.002.174	PROVIDER-CLAIM-FORM-CODE	Provider Claim Form Code
835	CRX175	CRX.002.175	PROVIDER-CLAIM-FORM-OTHER-TEXT	Provider Claim Form Other Text
836	CRX176	CRX.002.176	TOT-GME-AMOUNT-PAID	Total GME Amount Paid
837	CRX177	CRX.002.177	TOT-SDP-ALLOWED-AMT	Total State Directed Payment Allowed Amount

838	CRX178	CRX.002.178	TOT-SDP-PAID-AMT	Total State Directed Payment Paid Amount
839	CRX106	CRX.002.106	STATE-NOTATION	State Notation
840	CRX108	CRX.003.108	RECORD-ID	Record ID
841	CRX109	CRX.003.109	SUBMITTING-STATE	Submitting State
842	CRX110	CRX.003.110	RECORD-NUMBER	Record Number
843	CRX111	CRX.003.111	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
844	CRX112	CRX.003.112	ICN-ORIG	Original ICN

845	CRX113	CRX.003.113	ICN-ADJ	Adjustment ICN
846	CRX114	CRX.003.114	LINE-NUM-ORIG	Original Line Number
847	CRX115	CRX.003.115	LINE-NUM-ADJ	Adjustment Line Number
848	CRX116	CRX.003.116	LINE-ADJUSTMENT-IND	Line Adjustment Indicator
849	CRX117	CRX.003.117	LINE-ADJUSTMENT-REASON-CODE	Line Adjustment Reason Code
850	CRX118	CRX.003.118	SUBMITTER-ID	Submitter ID
851	CRX119	CRX.003.119	CLAIM-LINE-STATUS	Claim Line Status
852	CRX120	CRX.003.120	NATIONAL-DRUG-CODE	National Drug Code

853	CRX121	CRX.003.121	BILLED-AMT	Billed Amount
854	CRX122	CRX.003.122	ALLOWED-AMT	Allowed Amount
855	CRX123	CRX.003.123	BENEFICIARY-COPAYMENT-PAID-AMOUNT	Beneficiary Copayment Paid Amount
856	CRX124	CRX.003.124	TPL-AMT	Third Party Liability Amount

857	CRX125	CRX.003.125	MEDICAID-PAID-AMT	Medicaid Paid Amount
858	CRX126	CRX.003.126	MEDICAID-FFS-EQUIVALENT-AMT	Medicaid FFS Equivalent Amount
859	CRX127	CRX.003.127	MEDICARE-DEDUCTIBLE-AMT	Medicare Deductible Amount
860	CRX128	CRX.003.128	MEDICARE-COINS-AMT	Medicare Coinsurance Amount
861	CRX129	CRX.003.129	MEDICARE-PAID-AMT	Medicare Paid Amount

862	CRX131	CRX.003.131	PRESCRIPTION-QUANTITY-ALLOWED	Prescription Quantity Allowed
863	CRX132	CRX.003.132	PRESCRIPTION-QUANTITY-ACTUAL	Prescription Quantity Actual
864	CRX133	CRX.003.133	UNIT-OF-MEASURE	Unit of Measure
865	CRX134	CRX.003.134	TYPE-OF-SERVICE	Type of Service
866	CRX135	CRX.003.135	HCBS-SERVICE-CODE	HCBS Service Code

867	CRX136	CRX.003.136	HCBS-TAXONOMY	HCBS Taxonomy
868	CRX137	CRX.003.137	OTHER-TPL-COLLECTION	Other TPL Collection
869	CRX138	CRX.003.138	DAYS-SUPPLY	Days Supply
870	CRX139	CRX.003.139	NEW-REFILL-IND	New Refill Indicator
871	CRX140	CRX.003.140	BRAND-GENERIC-IND	Brand Generic Indicator

872	CRX141	CRX.003.141	DISPENSE-FEE-SUBMITTED	Dispense Fee Submitted
873	CRX142	CRX.003.142	PRESCRIPTION-NUM	Prescription Number
874	CRX143	CRX.003.143	DRUG-UTILIZATION-CODE	Drug Utilization Code
875	CRX144	CRX.003.144	DTL-METRIC-DEC-QTY	Metric Decimal Quantity
876	CRX145	CRX.003.145	COMPOUND-DOSAGE-FORM	Compound Dosage Form
877	CRX146	CRX.003.146	REBATE-ELIGIBLE-INDICATOR	Rebate Eligible Indicator

878	CRX149	CRX.003.149	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
879	CRX152	CRX.003.152	OTHER-INSURANCE-AMT	Other Insurance Amount
880	CRX157	CRX.003.157	ADJUDICATION-DATE	Adjudication Date
881	CRX158	CRX.003.158	SELF-DIRECTION-TYPE	Self Direction Type
882	CRX159	CRX.003.159	PRE-AUTHORIZATION-NUM	Preauthorization Number
883	CRX167	CRX.003.167	INGREDIENT-COST-SUBMITTED	Ingredient Cost Submitted
884	CRX168	CRX.003.168	INGREDIENT-COST-PAID-AMT	Ingredient Cost Paid Amount
885	CRX169	CRX.003.169	DISPENSE-FEE-PAID-AMT	Dispense Fee Paid Amount

886	CRX170	CRX.003.170	PROFESSIONAL-SERVICE-FEE-SUBMITTED	Professional Service Fee Submitted
887	CRX171	CRX.003.171	PROFESSIONAL-SERVICE-FEE-PAID-AMT	Professional Service Fee Paid Amount
888	CRX172	CRX.003.172	IHS-SERVICE-IND	IHS Service Indicator
889	CRX179	CRX.003.179	UNIQUE-DEVICE-IDENTIFIER	Unique Device Identifier
890	CRX209	CRX.003.209	MBESCBES-FORM-GROUP	MBESCBES Form Group
891	CRX181	CRX.003.181	MBESCBES-FORM	MBESCBES Form

892	CRX180	CRX.003.180	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service
893	CRX182	CRX.003.182	PROCEDURE-CODE	Procedure Code
894	CRX183	CRX.003.183	PROCEDURE-CODE-MOD-1	Procedure Code Modifier 1
895	CRX184	CRX.003.184	PROCEDURE-CODE-MOD-2	Procedure Code Modifier 2
896	CRX185	CRX.003.185	PROCEDURE-CODE-MOD-3	Procedure Code Modifier 3
897	CRX186	CRX.003.186	PROCEDURE-CODE-MOD-4	Procedure Code Modifier 4
898	CRX187	CRX.003.187	PROCEDURE-CODE-MOD-5	Procedure Code Modifier 5

899	CRX188	CRX.003.188	PROCEDURE-CODE-MOD-6	Procedure Code Modifier 6
900	CRX189	CRX.003.189	PROCEDURE-CODE-MOD-7	Procedure Code Modifier 7
901	CRX190	CRX.003.190	PROCEDURE-CODE-MOD-8	Procedure Code Modifier 8
902	CRX191	CRX.003.191	PROCEDURE-CODE-MOD-9	Procedure Code Modifier 9
903	CRX192	CRX.003.192	PROCEDURE-CODE-MOD-10	Procedure Code Modifier 10
904	CRX193	CRX.003.193	GME-AMOUNT-PAID	GME Amount Paid
905	CRX194	CRX.003.194	SDP-ALLOWED-AMT	State Directed Payment Allowed Amount
906	CRX195	CRX.003.195	SDP-PAID-AMT	State Directed Payment Paid Amount
907	CRX153	CRX.003.153	STATE-NOTATION	State Notation
908	CRX196	CRX.004.196	RECORD-ID	Record ID

909	CRX197	CRX.004.197	SUBMITTING-STATE	Submitting State
910	CRX198	CRX.004.198	RECORD-NUMBER	Record Number
911	CRX199	CRX.004.199	ICN-ORIG	Original ICN
912	CRX200	CRX.004.200	ICN-ADJ	Adjustment ICN
913	CRX201	CRX.004.201	ADJUSTMENT-IND	Adjustment Indicator
914	CRX202	CRX.004.202	ADJUDICATION-DATE	Adjudication Date
915	CRX203	CRX.004.203	DIAGNOSIS-TYPE	Diagnosis Type
916	CRX204	CRX.004.204	DIAGNOSIS-SEQUENCE-NUMBER	Diagnosis Sequence Number
917	CRX205	CRX.004.205	DIAGNOSIS-CODE-FLAG	Diagnosis Code Flag

918	CRX206	CRX.004.206	DIAGNOSIS-CODE	Diagnosis Code
919	CRX207	CRX.004.207	STATE-NOTATION	State Notation
920	ELG001	ELG.001.001	RECORD-ID	Record ID
921	ELG002	ELG.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version
922	ELG003	ELG.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type
923	ELG004	ELG.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification
924	ELG005	ELG.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version
925	ELG006	ELG.001.006	FILE-NAME	File Name
926	ELG007	ELG.001.007	SUBMITTING-STATE	Submitting State
927	ELG008	ELG.001.008	DATE-FILE-CREATED	Date File Created

928	ELG009	ELG.001.009	START-OF-TIME-PERIOD	Start of Time Period
929	ELG010	ELG.001.010	END-OF-TIME-PERIOD	End of Time Period
930	ELG011	ELG.001.011	FILE-STATUS-INDICATOR	File Status Indicator
931	ELG012	ELG.001.012	SSN-INDICATOR	SSN Indicator
932	ELG013	ELG.001.013	TOT-REC-CNT	Total Record Count
933	ELG272	ELG.001.272	FILE-SUBMISSION-METHOD	File Submission Method
934	ELG247	ELG.001.247	SEQUENCE-NUMBER	Sequence Number
935	ELG014	ELG.001.014	STATE-NOTATION	State Notation
936	ELG016	ELG.002.016	RECORD-ID	Record ID

937	ELG017	ELG.002.017	SUBMITTING-STATE	Submitting State
938	ELG018	ELG.002.018	RECORD-NUMBER	Record Number
939	ELG019	ELG.002.019	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
940	ELG020	ELG.002.020	ELIGIBLE-FIRST-NAME	Eligible First Name
941	ELG021	ELG.002.021	ELIGIBLE-LAST-NAME	Eligible Last Name
942	ELG022	ELG.002.022	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial
943	ELG023	ELG.002.023	SEX	Sex

944	ELG024	ELG.002.024	DATE-OF-BIRTH	Date of Birth
945	ELG025	ELG.002.025	DATE-OF-DEATH	Date of Death
946	ELG026	ELG.002.026	PRIMARY-DEMOGRAPHIC-ELEMENT-EFF-DATE	Primary Demographic Element Effective Date
947	ELG027	ELG.002.027	PRIMARY-DEMOGRAPHIC-ELEMENT-END-DATE	Primary Demographic Element End Date

948	ELG028	ELG.002.028	STATE-NOTATION	State Notation
949	ELG030	ELG.003.030	RECORD-ID	Record ID
950	ELG031	ELG.003.031	SUBMITTING-STATE	Submitting State
951	ELG032	ELG.003.032	RECORD-NUMBER	Record Number
952	ELG033	ELG.003.033	MSIS-IDENTIFICATION-NUM	MSIS Identification Number

953	ELG034	ELG.003.034	MARITAL-STATUS	Marital Status
954	ELG035	ELG.003.035	MARITAL-STATUS-OTHER-EXPLANATION	Marital Status Other Explanation
955	ELG036	ELG.003.036	SSN	SSN
956	ELG037	ELG.003.037	SSN-VERIFICATION-FLAG	SSN Verification Flag

957	ELG038	ELG.003.038	INCOME-CODE	Income Code
958	ELG039	ELG.003.039	VETERAN-IND	Veteran Indicator
959	ELG040	ELG.003.040	CITIZENSHIP-IND	Citizenship Indicator
960	ELG041	ELG.003.041	CITIZENSHIP-VERIFICATION-FLAG	Citizenship Verification Flag
961	ELG042	ELG.003.042	IMMIGRATION-STATUS	Immigration Status
962	ELG043	ELG.003.043	IMMIGRATION-VERIFICATION-FLAG	Immigration Verification Flag

963	ELG044	ELG.003.044	IMMIGRATION-STATUS-FIVE-YEAR-BAR-END-DATE	Immigration Status Five Year Bar End Date
964	ELG045	ELG.003.045	ENGL-PROF-CODE	English Proficiency Code
965	ELG046	ELG.003.046	PREFERRED-LANGUAGE-CODE	Primary Language Code
966	ELG047	ELG.003.047	HOUSEHOLD-SIZE	Household Size
967	ELG049	ELG.003.049	PREGNANCY-IND	Pregnancy Indicator
968	ELG050	ELG.003.050	MEDICARE-HIC-NUM	Medicare HIC Number

969	ELG051	ELG.003.051	MEDICARE-BENEFICIARY-IDENTIFIER	Medicare Beneficiary Identifier
970	ELG054	ELG.003.054	CHIP-CODE	CHIP Code
971	ELG057	ELG.003.057	VARIABLE-DEMOGRAPHIC-ELEMENT-EFF-DATE	Variable Demographic Element Effective Date
972	ELG058	ELG.003.058	VARIABLE-DEMOGRAPHIC-ELEMENT-END-DATE	Variable Demographic Element End Date

973	ELG269	ELG.003.269	ELIGIBLE-FEDERAL-POVERTY-LEVEL-PERCENTAGE	Eligible Federal Poverty Level Percentage
974	ELG273	ELG.003.273	APPLICATION-SIGNATURE-DATE	Application Signature Date
975	ELG059	ELG.003.059	STATE-NOTATION	State Notation
976	ELG061	ELG.004.061	RECORD-ID	Record ID
977	ELG062	ELG.004.062	SUBMITTING-STATE	Submitting State
978	ELG063	ELG.004.063	RECORD-NUMBER	Record Number

979	ELG064	ELG.004.064	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
980	ELG065	ELG.004.065	ELIGIBLE-ADDR-TYPE	Eligible Address Type
981	ELG066	ELG.004.066	ELIGIBLE-ADDR-LN1	Eligible Address Line 1
982	ELG067	ELG.004.067	ELIGIBLE-ADDR-LN2	Eligible Address Line 2
983	ELG068	ELG.004.068	ELIGIBLE-ADDR-LN3	Eligible Address Line 3
984	ELG069	ELG.004.069	ELIGIBLE-CITY	Eligible City
985	ELG070	ELG.004.070	ELIGIBLE-STATE	Eligible State
986	ELG071	ELG.004.071	ELIGIBLE-ZIP-CODE	Eligible ZIP Code

987	ELG072	ELG.004.072	ELIGIBLE-COUNTY-CODE	Eligible County Code
988	ELG073	ELG.004.073	ELIGIBLE-PHONE-NUM	Eligible Phone Number
989	ELG074	ELG.004.074	TYPE-OF-LIVING-ARRANGEMENT	Type Of Living Arrangement
990	ELG075	ELG.004.075	ELIGIBLE-ADDR-EFF-DATE	Eligible Address Effective Date
991	ELG076	ELG.004.076	ELIGIBLE-ADDR-END-DATE	Eligible Address End Date
992	ELG077	ELG.004.077	STATE-NOTATION	State Notation
993	ELG079	ELG.005.079	RECORD-ID	Record ID
994	ELG080	ELG.005.080	SUBMITTING-STATE	Submitting State
995	ELG081	ELG.005.081	RECORD-NUMBER	Record Number

996	ELG082	ELG.005.082	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
997	ELG083	ELG.005.083	MSIS-CASE-NUM	MSIS Case Num
998	ELG085	ELG.005.085	DUAL-ELIGIBLE-CODE	Dual Eligible Code

999	ELG086	ELG.005.086	PRIMARY-ELIGIBILITY-GROUP-IND	Primary Eligibility Group Indicator
1000	ELG087	ELG.005.087	ELIGIBILITY-GROUP	Eligibility Group
1001	ELG088	ELG.005.088	LEVEL-OF-CARE-STATUS	Level Of Care Status
1002	ELG089	ELG.005.089	SSDI-IND	SSDI Indicator

1003	ELG090	ELG.005.090	SSI-IND	SSI Indicator
1004	ELG091	ELG.005.091	SSI-STATE-SUPPLEMENT-STATUS-CODE	SSI State Supplement Status Code
1005	ELG092	ELG.005.092	SSI-STATUS	SSI Status
1006	ELG093	ELG.005.093	STATE-SPEC-ELIG-GROUP	State Specific Eligibility Group
1007	ELG094	ELG.005.094	CONCEPTION-TO-BIRTH-IND	Conception To Birth Indicator

1008	ELG095	ELG.005.095	ELIGIBILITY-TERMINATION-REASON	Eligibility Termination Reason
1009	ELG097	ELG.005.097	RESTRICTED-BENEFITS-CODE	Restricted Benefits Code

1010	ELG098	ELG.005.098	TANF-CASH-CODE	TANF Cash Code
1011	ELG099	ELG.005.099	ELIGIBILITY-DETERMINANT-EFF-DATE	Eligibility Determinant Effective Date
1012	ELG100	ELG.005.100	ELIGIBILITY-DETERMINANT-END-DATE	Eligibility Determinant End Date
1013	ELG274	ELG.005.274	ELIGIBILITY-REDETERMINATION-DATE	Eligibility Redetermination Date
1014	ELG275	ELG.005.275	ELIGIBILITY-EXTENSION-CODE	Eligibility Extension Code
1015	ELG276	ELG.005.276	ELIGIBILITY-EXTENSION-OTHER-TEXT	Eligibility Extension Other Text
1016	ELG277	ELG.005.277	CONTINUOUS-ELIGIBILITY-CODE	Continuous Eligibility Code
1017	ELG278	ELG.005.278	CONTINUOUS-ELIGIBILITY-OTHER-TEXT	Continuous Eligibility Other Text
1018	ELG279	ELG.005.279	INCOME-STANDARD-CODE	Income Standard Code
1019	ELG280	ELG.005.280	INCOME-STANDARD-OTHER-TEXT	Income Standard Other Text
1020	ELG281	ELG.005.281	ELIGIBILITY-TERMINATION-REASON-OTHER-TYPE-TEXT	Eligibility Termination Reason Other Type Text

1021	ELG101	ELG.005.101	STATE-NOTATION	State Notation
1022	ELG103	ELG.006.103	RECORD-ID	Record ID
1023	ELG104	ELG.006.104	SUBMITTING-STATE	Submitting State
1024	ELG105	ELG.006.105	RECORD-NUMBER	Record Number
1025	ELG106	ELG.006.106	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1026	ELG107	ELG.006.107	HEALTH-HOME-SPA-NAME	Health Home SPA Name
1027	ELG108	ELG.006.108	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name
1028	ELG109	ELG.006.109	HEALTH-HOME-SPA-PARTICIPATION-EFF-DATE	Health Home SPA Participation Effective Date

1029	ELG110	ELG.006.110	HEALTH-HOME-SPA-PARTICIPATION-END-DATE	Health Home SPA Participation End Date
1030	ELG111	ELG.006.111	HEALTH-HOME-ENTITY-EFF-DATE	Health Home Entity Effective Date
1031	ELG112	ELG.006.112	STATE-NOTATION	State Notation
1032	ELG114	ELG.007.114	RECORD-ID	Record ID
1033	ELG115	ELG.007.115	SUBMITTING-STATE	Submitting State
1034	ELG116	ELG.007.116	RECORD-NUMBER	Record Number
1035	ELG117	ELG.007.117	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1036	ELG118	ELG.007.118	HEALTH-HOME-SPA-NAME	Health Home SPA Name
1037	ELG119	ELG.007.119	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name

1038	ELG120	ELG.007.120	HEALTH-HOME-PROV-NUM	Health Home Provider Number
1039	ELG121	ELG.007.121	HEALTH-HOME-SPA-PROVIDER-EFF-DATE	Health Home SPA Provider Effective Date
1040	ELG122	ELG.007.122	HEALTH-HOME-SPA-PROVIDER-END-DATE	Health Home Spa Provider End Date
1041	ELG123	ELG.007.123	HEALTH-HOME-ENTITY-EFF-DATE	Health Home Entity Effective Date
1042	ELG124	ELG.007.124	STATE-NOTATION	State Notation
1043	ELG126	ELG.008.126	RECORD-ID	Record ID
1044	ELG127	ELG.008.127	SUBMITTING-STATE	Submitting State
1045	ELG128	ELG.008.128	RECORD-NUMBER	Record Number

1046	ELG129	ELG.008.129	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1047	ELG130	ELG.008.130	HEALTH-HOME-CHRONIC-CONDITION	Health Home Chronic Condition
1048	ELG131	ELG.008.131	HEALTH-HOME-CHRONIC-CONDITION-OTHER-EXPLANATION	Health Home Chronic Condition Other Explanation
1049	ELG132	ELG.008.132	HEALTH-HOME-CHRONIC-CONDITION-EFF-DATE	Health Home Chronic Condition Effective Date
1050	ELG133	ELG.008.133	HEALTH-HOME-CHRONIC-CONDITION-END-DATE	Health Home Chronic Condition End Date
1051	ELG134	ELG.008.134	STATE-NOTATION	State Notation
1052	ELG136	ELG.009.136	RECORD-ID	Record ID

1053	ELG137	ELG.009.137	SUBMITTING-STATE	Submitting State
1054	ELG138	ELG.009.138	RECORD-NUMBER	Record Number
1055	ELG139	ELG.009.139	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1056	ELG140	ELG.009.140	LOCKIN-PROV-NUM	Lockin Provider Num
1057	ELG141	ELG.009.141	LOCKIN-PROV-TYPE	Lockin Provider Type
1058	ELG142	ELG.009.142	LOCKIN-EFF-DATE	Lockin Effective Date
1059	ELG143	ELG.009.143	LOCKIN-END-DATE	Lockin End Date
1060	ELG270	ELG.009.270	LOCKED-IN-SRVCS	Locked In Services
1061	ELG144	ELG.009.144	STATE-NOTATION	State Notation

1062	ELG146	ELG.010.146	RECORD-ID	Record ID
1063	ELG147	ELG.010.147	SUBMITTING-STATE	Submitting State
1064	ELG148	ELG.010.148	RECORD-NUMBER	Record Number
1065	ELG149	ELG.010.149	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1066	ELG150	ELG.010.150	MFP-LIVES-WITH-FAMILY	MFP Lives with Family
1067	ELG151	ELG.010.151	MFP-QUALIFIED-INSTITUTION	MFP Qualified Institution
1068	ELG152	ELG.010.152	MFP-QUALIFIED-RESIDENCE	MFP Qualified Residence
1069	ELG153	ELG.010.153	MFP-REASON-PARTICIPATION-ENDED	MFP Reason Participation Ended

1070	ELG154	ELG.010.154	MFP-REINSTITUTIONALIZED-REASON	MFP Reinstitutionalized Reason
1071	ELG155	ELG.010.155	MFP-ENROLLMENT-EFF-DATE	MFP Enrollment Effective Date
1072	ELG156	ELG.010.156	MFP-ENROLLMENT-END-DATE	MFP Enrollment End Date
1073	ELG157	ELG.010.157	STATE-NOTATION	State Notation
1074	ELG159	ELG.011.159	RECORD-ID	Record ID
1075	ELG160	ELG.011.160	SUBMITTING-STATE	Submitting State
1076	ELG161	ELG.011.161	RECORD-NUMBER	Record Number
1077	ELG162	ELG.011.162	MSIS-IDENTIFICATION-NUM	MSIS Identification Number

1078	ELG163	ELG.011.163	STATE-PLAN-OPTION-TYPE	State Plan Option Type
1079	ELG164	ELG.011.164	STATE-PLAN-OPTION-EFF-DATE	State Plan Option Effective Date
1080	ELG165	ELG.011.165	STATE-PLAN-OPTION-END-DATE	State Plan Option End Date
1081	ELG166	ELG.011.166	STATE-NOTATION	State Notation
1082	ELG168	ELG.012.168	RECORD-ID	Record ID
1083	ELG169	ELG.012.169	SUBMITTING-STATE	Submitting State
1084	ELG170	ELG.012.170	RECORD-NUMBER	Record Number

1085	ELG171	ELG.012.171	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1086	ELG172	ELG.012.172	WAIVER-ID	Waiver ID
1087	ELG173	ELG.012.173	WAIVER-TYPE	Eligible Waiver Type
1088	ELG174	ELG.012.174	WAIVER-ENROLLMENT-EFF-DATE	Waiver Enrollment Effective Date
1089	ELG175	ELG.012.175	WAIVER-ENROLLMENT-END-DATE	Waiver Enrollment End Date
1090	ELG176	ELG.012.176	STATE-NOTATION	State Notation

1091	ELG178	ELG.013.178	RECORD-ID	Record ID
1092	ELG179	ELG.013.179	SUBMITTING-STATE	Submitting State
1093	ELG180	ELG.013.180	RECORD-NUMBER	Record Number
1094	ELG181	ELG.013.181	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1095	ELG182	ELG.013.182	LTSS-LEVEL-CARE	LTSS Level of Care
1096	ELG183	ELG.013.183	LTSS-PROV-NUM	LTSS Provider Num
1097	ELG184	ELG.013.184	LTSS-ELIGIBILITY-EFF-DATE	LTSS Eligibility Effective Date
1098	ELG185	ELG.013.185	LTSS-ELIGIBILITY-END-DATE	LTSS Eligibility End Date
1099	ELG186	ELG.013.186	STATE-NOTATION	State Notation

1100	ELG188	ELG.014.188	RECORD-ID	Record ID
1101	ELG189	ELG.014.189	SUBMITTING-STATE	Submitting State
1102	ELG190	ELG.014.190	RECORD-NUMBER	Record Number
1103	ELG191	ELG.014.191	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1104	ELG192	ELG.014.192	MANAGED-CARE-PLAN-ID	Managed Care Plan ID

1105	ELG193	ELG.014.193	MANAGED-CARE-PLAN-TYPE	Managed Care Plan Type
1106	ELG196	ELG.014.196	MANAGED-CARE-PLAN-ENROLLMENT-EFF-DATE	Managed Care Plan Enrollment Effective Date
1107	ELG197	ELG.014.197	MANAGED-CARE-PLAN-ENROLLMENT-END-DATE	Managed Care Plan Enrollment End Date
1108	ELG198	ELG.014.198	STATE-NOTATION	State Notation
1109	ELG200	ELG.015.200	RECORD-ID	Record ID
1110	ELG201	ELG.015.201	SUBMITTING-STATE	Submitting State
1111	ELG202	ELG.015.202	RECORD-NUMBER	Record Number

1112	ELG203	ELG.015.203	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1113	ELG204	ELG.015.204	ETHNICITY-CODE	Ethnicity Code
1114	ELG205	ELG.015.205	ETHNICITY-DECLARATION-EFF-DATE	Ethnicity Declaration Effective Date
1115	ELG206	ELG.015.206	ETHNICITY-DECLARATION-END-DATE	Ethnicity Declaration End Date
1116	ELG271	ELG.015.271	ETHNICITY-OTHER	Ethnicity Other
1117	ELG207	ELG.015.207	STATE-NOTATION	State Notation

1118	ELG209	ELG.016.209	RECORD-ID	Record ID
1119	ELG210	ELG.016.210	SUBMITTING-STATE	Submitting State
1120	ELG211	ELG.016.211	RECORD-NUMBER	Record Number
1121	ELG212	ELG.016.212	MSIS-IDENTIFICATION-NUM	MSIS Identification Number

1122	ELG213	ELG.016.213	RACE	Race
1123	ELG214	ELG.016.214	RACE-OTHER	Race Other

1124	ELG215	ELG.016.215	AMERICAN-INDIAN-ALASKA-NATIVE-INDICATOR	American Indian Alaska Native Indicator
1125	ELG216	ELG.016.216	RACE-DECLARATION-EFF-DATE	Race Declaration Effective Date
1126	ELG217	ELG.016.217	RACE-DECLARATION-END-DATE	Race Declaration End Date
1127	ELG218	ELG.016.218	STATE-NOTATION	State Notation
1128	ELG220	ELG.017.220	RECORD-ID	Record ID

1129	ELG221	ELG.017.221	SUBMITTING-STATE	Submitting State
1130	ELG222	ELG.017.222	RECORD-NUMBER	Record Number
1131	ELG223	ELG.017.223	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1132	ELG224	ELG.017.224	DISABILITY-TYPE-CODE	Disability Type Code
1133	ELG225	ELG.017.225	DISABILITY-TYPE-EFF-DATE	Disability Type Effective Date
1134	ELG226	ELG.017.226	DISABILITY-TYPE-END-DATE	Disability Type End Date
1135	ELG227	ELG.017.227	STATE-NOTATION	State Notation
1136	ELG229	ELG.018.229	RECORD-ID	Record ID

1137	ELG230	ELG.018.230	SUBMITTING-STATE	Submitting State
1138	ELG231	ELG.018.231	RECORD-NUMBER	Record Number
1139	ELG232	ELG.018.232	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1140	ELG233	ELG.018.233	1115A-DEMONSTRATION-IND	1115A Demonstration Indicator
1141	ELG234	ELG.018.234	1115A-EFF-DATE	1115A Effective Date
1142	ELG235	ELG.018.235	1115A-END-DATE	1115A End Date
1143	ELG236	ELG.018.236	STATE-NOTATION	State Notation
1144	ELG238	ELG.020.238	RECORD-ID	Record ID

1145	ELG239	ELG.020.239	SUBMITTING-STATE	Submitting State
1146	ELG240	ELG.020.240	RECORD-NUMBER	Record Number
1147	ELG241	ELG.020.241	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1148	ELG242	ELG.020.242	HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-CODE	HCBS Chronic Condition Non Health Home Code
1149	ELG243	ELG.020.243	HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-EFF-DATE	HCBS Chronic Condition Non Health Home Effective Date
1150	ELG244	ELG.020.244	HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-END-DATE	HCBS Chronic Condition Non Health Home End Date
1151	ELG245	ELG.020.245	STATE-NOTATION	State Notation
1152	ELG248	ELG.021.248	RECORD-ID	Record ID

1153	ELG249	ELG.021.249	SUBMITTING-STATE	Submitting State
1154	ELG250	ELG.021.250	RECORD-NUMBER	Record Number
1155	ELG251	ELG.021.251	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1156	ELG252	ELG.021.252	ENROLLMENT-TYPE	Enrollment Type
1157	ELG253	ELG.021.253	ENROLLMENT-EFF-DATE	Enrollment Effective Date
1158	ELG254	ELG.021.254	ENROLLMENT-END-DATE	Enrollment End Date
1159	ELG255	ELG.021.255	STATE-NOTATION	State Notation

1160	ELG257	ELG.022.257	RECORD-ID	Record ID
1161	ELG258	ELG.022.258	SUBMITTING-STATE	Submitting State
1162	ELG259	ELG.022.259	RECORD-NUMBER	Record Number
1163	ELG260	ELG.022.260	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1164	ELG261	ELG.022.261	ELG-IDENTIFIER-TYPE	Eligible Identifier Type
1165	ELG262	ELG.022.262	ELG-IDENTIFIER-ISSUING-ENTITY-ID	Eligible Identifier Issuing Entity Identifier
1166	ELG263	ELG.022.263	ELG-IDENTIFIER-EFF-DATE	Eligible Identifier Effective Date
1167	ELG264	ELG.022.264	ELG-IDENTIFIER-END-DATE	Eligible Identifier End Date

1168	ELG265	ELG.022.265	ELG-IDENTIFIER	Eligible Identifier
1169	ELG266	ELG.022.266	REASON-FOR-CHANGE	Reason for Change
1170	ELG267	ELG.022.267	STATE-NOTATION	State Notation
1171	ELG282	ELG.023.282	RECORD-ID	Record ID

1172	ELG283	ELG.023.283	SUBMITTING-STATE	Submitting State
1173	ELG284	ELG.023.284	RECORD-NUMBER	Record Number
1174	ELG285	ELG.023.285	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1175	ELG286	ELG.023.286	SEX-ASSIGNED-AT-BIRTH	Sex Assigned at Birth
1176	ELG287	ELG.023.287	SEX-ASSIGNED-AT-BIRTH-OTHER-TEXT	Sex Assigned at Birth Other Text

1177	ELG288	ELG.023.288	GENDER-IDENTITY	Gender Identity
1178	ELG289	ELG.023.289	GENDER-IDENTITY-OTHER-TEXT	Gender Identity Other Text
1179	ELG290	ELG.023.290	SEXUAL-ORIENTATION	Sexual Orientation
1180	ELG291	ELG.023.291	SEXUAL-ORIENTATION-OTHER-TEXT	Sexual Orientation Other Text
1181	ELG292	ELG.023.292	SOGI-EFF-DATE	SOGI Effective Date
1182	ELG293	ELG.023.293	SOGI-END-DATE	SOGI End Date
1183	ELG294	ELG.023.294	STATE-NOTATION	State Notation

1184	FTX001	FTX.001.001	RECORD-ID	Record ID
1185	FTX002	FTX.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version
1186	FTX003	FTX.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type
1187	FTX004	FTX.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification
1188	FTX005	FTX.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version
1189	FTX006	FTX.001.006	FILE-NAME	File Name
1190	FTX007	FTX.001.007	SUBMITTING-STATE	Submitting State
1191	FTX008	FTX.001.008	DATE-FILE-CREATED	Date File Created
1192	FTX009	FTX.001.009	START-OF-TIME-PERIOD	Start of Time Period
1193	FTX010	FTX.001.010	END-OF-TIME-PERIOD	End of Time Period

1194	FTX011	FTX.001.011	FILE-STATUS-INDICATOR	File Status Indicator
1195	FTX012	FTX.001.012	SSN-INDICATOR	SSN Indicator
1196	FTX013	FTX.001.013	TOT-REC-CNT	Total Record Count
1197	FTX014	FTX.001.014	SEQUENCE-NUMBER	Sequence Number
1198	FTX015	FTX.001.015	STATE-NOTATION	State Notation
1199	FTX017	FTX.002.017	RECORD-ID	Record ID
1200	FTX018	FTX.002.018	SUBMITTING-STATE	Submitting State
1201	FTX019	FTX.002.019	RECORD-NUMBER	Record Number
1202	FTX020	FTX.002.020	ICN-ORIG	Original ICN

1203	FTX021	FTX.002.021	ICN-ADJ	Adjustment ICN
1204	FTX023	FTX.002.023	ADJUSTMENT-IND	Adjustment Indicator
1205	FTX024	FTX.002.024	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date
1206	FTX025	FTX.002.025	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount
1207	FTX026	FTX.002.026	CHECK-EFF-DATE	Check Effective Date
1208	FTX027	FTX.002.027	CHECK-NUM	Check Number
1209	FTX028	FTX.002.028	PAYER-ID	Payer ID
1210	FTX029	FTX.002.029	PAYER-ID-TYPE	Payer ID Type

1211	FTX030	FTX.002.030	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text
1212	FTX031	FTX.002.031	PAYER-MCR-PLAN-TYPE	Payer MCR Plan Type
1213	FTX032	FTX.002.032	PAYER-MCR-PLAN-TYPE-OTHER-TEXT	Payer MCR Plan Type Other Text
1214	FTX033	FTX.002.033	PAYEE-ID	Payee Identifier
1215	FTX034	FTX.002.034	PAYEE-ID-TYPE	Payee Identifier Type
1216	FTX035	FTX.002.035	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text
1217	FTX036	FTX.002.036	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type

1218	FTX037	FTX.002.037	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text
1219	FTX038	FTX.002.038	PAYEE-TAX-ID	Payee Tax ID
1220	FTX039	FTX.002.039	PAYEE-TAX-ID-TYPE	Payee Tax ID Type
1221	FTX040	FTX.002.040	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text
1222	FTX041	FTX.002.041	CONTRACT-ID	Contract Identifier
1223	FTX042	FTX.002.042	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1224	FTX043	FTX.002.043	CAPITATION-PERIOD-START-DATE	Capitation Period Start Date
1225	FTX044	FTX.002.044	CAPITATION-PERIOD-END-DATE	Capitation Period End Date

1226	FTX045	FTX.002.045	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
1227	FTX048	FTX.002.048	MBESCBES-FORM-GROUP	MBESCBES Form Group
1228	FTX047	FTX.002.047	MBESCBES-FORM	MBESCBES Form
1229	FTX046	FTX.002.046	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service

1230	FTX049	FTX.002.049	WAIVER-ID	Waiver ID
1231	FTX050	FTX.002.050	WAIVER-TYPE	Waiver Type
1232	FTX051	FTX.002.051	FUNDING-CODE	Funding Code
1233	FTX052	FTX.002.052	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share
1234	FTX053	FTX.002.053	SDP-IND	State Directed Payment Indicator
1235	FTX054	FTX.002.054	SOURCE-LOCATION	Source Location
1236	FTX055	FTX.002.055	SPA-NUMBER	SPA Number

1237	FTX056	FTX.002.056	SUBCAPITATION-IND	Subcapitation Ind
1238	FTX057	FTX.002.057	PAYMENT-CAT-XREF	Payment Cat Xref
1239	FTX058	FTX.002.058	RATE-CELL-DESCRIPTION-TEXT	Rate Cell Description Text
1240	FTX059	FTX.002.059	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type
1241	FTX060	FTX.002.060	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text
1242	FTX061	FTX.002.061	MEMO	Memo
1243	FTX062	FTX.002.062	STATE-NOTATION	State Notation
1244	FTX064	FTX.003.064	RECORD-ID	Record ID
1245	FTX065	FTX.003.065	SUBMITTING-STATE	Submitting State

1246	FTX066	FTX.003.066	RECORD-NUMBER	Record Number
1247	FTX067	FTX.003.067	ICN-ORIG	Original ICN
1248	FTX068	FTX.003.068	ICN-ADJ	Adjustment ICN
1249	FTX070	FTX.003.070	ADJUSTMENT-IND	Adjustment Indicator
1250	FTX071	FTX.003.071	PAYMENT-OR-RECOUPMENT-DATE	Payment Date
1251	FTX072	FTX.003.072	PAYMENT-AMOUNT	Payment Amount
1252	FTX073	FTX.003.073	CHECK-EFF-DATE	Check Effective Date
1253	FTX074	FTX.003.074	CHECK-NUM	Check Number
1254	FTX075	FTX.003.075	PAYER-ID	Payer ID

1255	FTX076	FTX.003.076	PAYER-ID-TYPE	Payer ID Type
1256	FTX077	FTX.003.077	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text
1257	FTX078	FTX.003.078	PAYEE-ID	Payee Identifier
1258	FTX079	FTX.003.079	PAYEE-ID-TYPE	Payee Identifier Type
1259	FTX080	FTX.003.080	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text
1260	FTX081	FTX.003.081	PAYEE-TAX-ID	Payee Tax ID

1261	FTX082	FTX.003.082	PAYEE-TAX-ID-TYPE	Payee Tax ID Type
1262	FTX083	FTX.003.083	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text
1263	FTX084	FTX.003.084	INSURANCE-CARRIER-ID-NUM	Insurance Carrier Identification Number
1264	FTX085	FTX.003.085	INSURANCE-PLAN-ID	Insurance Plan Identifier
1265	FTX086	FTX.003.086	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1266	FTX087	FTX.003.087	MEMBER-ID	Member Identifier
1267	FTX088	FTX.003.088	PREMIUM-PERIOD-START-DATE	Premium Period Start Date
1268	FTX089	FTX.003.089	PREMIUM-PERIOD-END-DATE	Premium Period End Date
1269	FTX090	FTX.003.090	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
1270	FTX093	FTX.003.093	MBESCBES-FORM-GROUP	MBESCBES Form Group

1271	FTX092	FTX.003.092	MBESCBES-FORM	MBESCBES Form
1272	FTX091	FTX.003.091	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service
1273	FTX094	FTX.003.094	WAIVER-ID	Waiver ID
1274	FTX095	FTX.003.095	WAIVER-TYPE	Waiver Type

1275	FTX096	FTX.003.096	FUNDING-CODE	Funding Code
1276	FTX097	FTX.003.097	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share
1277	FTX098	FTX.003.098	SOURCE-LOCATION	Source Location
1278	FTX099	FTX.003.099	SPA-NUMBER	SPA Number
1279	FTX100	FTX.003.100	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type
1280	FTX101	FTX.003.101	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text
1281	FTX102	FTX.003.102	MEMO	Memo
1282	FTX103	FTX.003.103	STATE-NOTATION	State Notation

1283	FTX105	FTX.004.105	RECORD-ID	Record ID
1284	FTX106	FTX.004.106	SUBMITTING-STATE	Submitting State
1285	FTX107	FTX.004.107	RECORD-NUMBER	Record Number
1286	FTX108	FTX.004.108	ICN-ORIG	Original ICN
1287	FTX109	FTX.004.109	ICN-ADJ	Adjustment ICN
1288	FTX111	FTX.004.111	ADJUSTMENT-IND	Adjustment Indicator
1289	FTX112	FTX.004.112	PAYMENT-DATE	Payment Date
1290	FTX113	FTX.004.113	PAYMENT-AMOUNT	Payment Amount
1291	FTX114	FTX.004.114	CHECK-EFF-DATE	Check Effective Date
1292	FTX115	FTX.004.115	CHECK-NUM	Check Number

1293	FTX116	FTX.004.116	PAYER-ID	Payer ID
1294	FTX117	FTX.004.117	PAYER-ID-TYPE	Payer ID Type
1295	FTX118	FTX.004.118	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text
1296	FTX119	FTX.004.119	PAYEE-ID	Payee Identifier
1297	FTX120	FTX.004.120	PAYEE-ID-TYPE	Payee Identifier Type
1298	FTX121	FTX.004.121	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text

1299	FTX122	FTX.004.122	PAYEE-TAX-ID	Payee Tax ID
1300	FTX123	FTX.004.123	PAYEE-TAX-ID-TYPE	Payee Tax ID Type
1301	FTX124	FTX.004.124	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text
1302	FTX125	FTX.004.125	INSURANCE-CARRIER-ID-NUM	Insurance Carrier Identification Number
1303	FTX126	FTX.004.126	INSURANCE-PLAN-ID	Insurance Plan Identifier
1304	FTX127	FTX.004.127	MSIS-IDENTIFICATION-NUM	MSIS Identification Number

1305	FTX128	FTX.004.128	SSN	SSN
1306	FTX129	FTX.004.129	MEMBER-ID	Member Identifier
1307	FTX130	FTX.004.130	GROUP-NUM	Group Num
1308	FTX131	FTX.004.131	POLICY-OWNER-CODE	Policy Owner Code
1309	FTX132	FTX.004.132	PREMIUM-PERIOD-START-DATE	Premium Period Start Date
1310	FTX133	FTX.004.133	PREMIUM-PERIOD-END-DATE	Premium Period End Date
1311	FTX134	FTX.004.134	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
1312	FTX137	FTX.004.137	MBESCBES-FORM-GROUP	MBESCBES Form Group
1313	FTX136	FTX.004.136	MBESCBES-FORM	MBESCBES Form

1314	FTX135	FTX.004.135	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service
1315	FTX138	FTX.004.138	WAIVER-ID	Waiver ID
1316	FTX139	FTX.004.139	WAIVER-TYPE	Waiver Type
1317	FTX140	FTX.004.140	FUNDING-CODE	Funding Code

1318	FTX141	FTX.004.141	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share
1319	FTX142	FTX.004.142	SOURCE-LOCATION	Source Location
1320	FTX143	FTX.004.143	SPA-NUMBER	SPA Number
1321	FTX144	FTX.004.144	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type
1322	FTX145	FTX.004.145	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text
1323	FTX146	FTX.004.146	MEMO	Memo
1324	FTX147	FTX.004.147	STATE-NOTATION	State Notation
1325	FTX149	FTX.005.149	RECORD-ID	Record ID

1326	FTX150	FTX.005.150	SUBMITTING-STATE	Submitting State
1327	FTX151	FTX.005.151	RECORD-NUMBER	Record Number
1328	FTX152	FTX.005.152	ICN-ORIG	Original ICN
1329	FTX153	FTX.005.153	ICN-ADJ	Adjustment ICN
1330	FTX155	FTX.005.155	ADJUSTMENT-IND	Adjustment Indicator
1331	FTX156	FTX.005.156	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date
1332	FTX157	FTX.005.157	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount
1333	FTX158	FTX.005.158	CHECK-EFF-DATE	Check Effective Date
1334	FTX159	FTX.005.159	CHECK-NUM	Check Number
1335	FTX160	FTX.005.160	PAYER-ID	Payer ID

1336	FTX161	FTX.005.161	PAYER-ID-TYPE	Payer ID Type
1337	FTX162	FTX.005.162	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text
1338	FTX163	FTX.005.163	PAYEE-ID	Payee Identifier
1339	FTX164	FTX.005.164	PAYEE-ID-TYPE	Payee Identifier Type
1340	FTX165	FTX.005.165	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text
1341	FTX166	FTX.005.166	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type
1342	FTX167	FTX.005.167	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text

1343	FTX168	FTX.005.168	PAYEE-TAX-ID	Payee Tax ID
1344	FTX169	FTX.005.169	PAYEE-TAX-ID-TYPE	Payee Tax ID Type
1345	FTX170	FTX.005.170	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text
1346	FTX171	FTX.005.171	CONTRACT-ID	Contract Identifier
1347	FTX172	FTX.005.172	INSURANCE-PLAN-ID	Insurance Plan Identifier
1348	FTX173	FTX.005.173	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1349	FTX174	FTX.005.174	COVERAGE-PERIOD-START-DATE	Coverage Period Start Date

1350	FTX175	FTX.005.175	COVERAGE-PERIOD-END-DATE	Coverage Period End Date
1351	FTX176	FTX.005.176	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
1352	FTX179	FTX.005.179	MBESCBES-FORM-GROUP	MBESCBES Form Group
1353	FTX178	FTX.005.178	MBESCBES-FORM	MBESCBES Form
1354	FTX177	FTX.005.177	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service

1355	FTX180	FTX.005.180	WAIVER-ID	Waiver ID
1356	FTX181	FTX.005.181	WAIVER-TYPE	Waiver Type
1357	FTX182	FTX.005.182	FUNDING-CODE	Funding Code
1358	FTX183	FTX.005.183	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share
1359	FTX184	FTX.005.184	OFFSET-TRANS-TYPE	Offset Trans Type
1360	FTX185	FTX.005.185	SOURCE-LOCATION	Source Location
1361	FTX186	FTX.005.186	SPA-NUMBER	SPA Number

1362	FTX187	FTX.005.187	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type
1363	FTX188	FTX.005.188	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text
1364	FTX189	FTX.005.189	MEMO	Memo
1365	FTX190	FTX.005.190	STATE-NOTATION	State Notation
1366	FTX192	FTX.006.192	RECORD-ID	Record ID
1367	FTX193	FTX.006.193	SUBMITTING-STATE	Submitting State
1368	FTX194	FTX.006.194	RECORD-NUMBER	Record Number
1369	FTX195	FTX.006.195	ICN-ORIG	Original ICN
1370	FTX196	FTX.006.196	ICN-ADJ	Adjustment ICN
1371	FTX198	FTX.006.198	ADJUSTMENT-IND	Adjustment Indicator

1372	FTX199	FTX.006.199	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date
1373	FTX200	FTX.006.200	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount
1374	FTX201	FTX.006.201	CHECK-EFF-DATE	Check Effective Date
1375	FTX202	FTX.006.202	CHECK-NUM	Check Number
1376	FTX203	FTX.006.203	PAYER-ID	Payer ID
1377	FTX204	FTX.006.204	PAYER-ID-TYPE	Payer ID Type
1378	FTX205	FTX.006.205	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text
1379	FTX206	FTX.006.206	PAYEE-ID	Payee Identifier

1380	FTX207	FTX.006.207	PAYEE-ID-TYPE	Payee Identifier Type
1381	FTX208	FTX.006.208	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text
1382	FTX209	FTX.006.209	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type
1383	FTX210	FTX.006.210	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text
1384	FTX211	FTX.006.211	PAYEE-TAX-ID	Payee Tax ID
1385	FTX212	FTX.006.212	PAYEE-TAX-ID-TYPE	Payee Tax ID Type
1386	FTX213	FTX.006.213	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text
1387	FTX214	FTX.006.214	CONTRACT-ID	Contract Identifier

1388	FTX215	FTX.006.215	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1389	FTX216	FTX.006.216	PERFORMANCE-PERIOD-START-DATE	Performance Period Start Date
1390	FTX217	FTX.006.217	PERFORMANCE-PERIOD-END-DATE	Performance Period End Date
1391	FTX218	FTX.006.218	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
1392	FTX221	FTX.006.221	MBESCBES-FORM-GROUP	MBESCBES Form Group
1393	FTX220	FTX.006.220	MBESCBES-FORM	MBESCBES Form

1394	FTX219	FTX.006.219	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service
1395	FTX222	FTX.006.222	WAIVER-ID	Waiver ID
1396	FTX223	FTX.006.223	WAIVER-TYPE	Waiver Type
1397	FTX224	FTX.006.224	FUNDING-CODE	Funding Code
1398	FTX225	FTX.006.225	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share
1399	FTX226	FTX.006.226	SDP-IND	State Directed Payment Indicator

1400	FTX227	FTX.006.227	SOURCE-LOCATION	Source Location
1401	FTX228	FTX.006.228	SPA-NUMBER	SPA Number
1402	FTX229	FTX.006.229	VALUE-BASED-PAYMENT-MODEL-TYPE	Value Based Payment Model Type
1403	FTX230	FTX.006.230	PAYMENT-CAT-XREF	Payment Cat Xref
1404	FTX231	FTX.006.231	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type
1405	FTX232	FTX.006.232	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text
1406	FTX233	FTX.006.233	MEMO	Memo
1407	FTX234	FTX.006.234	STATE-NOTATION	State Notation

1408	FTX236	FTX.007.236	RECORD-ID	Record ID
1409	FTX237	FTX.007.237	SUBMITTING-STATE	Submitting State
1410	FTX238	FTX.007.238	RECORD-NUMBER	Record Number
1411	FTX239	FTX.007.239	ICN-ORIG	Original ICN
1412	FTX240	FTX.007.240	ICN-ADJ	Adjustment ICN
1413	FTX242	FTX.007.242	ADJUSTMENT-IND	Adjustment Indicator
1414	FTX243	FTX.007.243	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date
1415	FTX244	FTX.007.244	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount
1416	FTX245	FTX.007.245	CHECK-EFF-DATE	Check Effective Date
1417	FTX246	FTX.007.246	CHECK-NUM	Check Number

1418	FTX247	FTX.007.247	PAYER-ID	Payer ID
1419	FTX248	FTX.007.248	PAYER-ID-TYPE	Payer ID Type
1420	FTX249	FTX.007.249	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text
1421	FTX250	FTX.007.250	PAYEE-ID	Payee Identifier
1422	FTX251	FTX.007.251	PAYEE-ID-TYPE	Payee Identifier Type

1423	FTX252	FTX.007.252	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text
1424	FTX253	FTX.007.253	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type
1425	FTX254	FTX.007.254	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text
1426	FTX255	FTX.007.255	PAYEE-TAX-ID	Payee Tax ID
1427	FTX256	FTX.007.256	PAYEE-TAX-ID-TYPE	Payee Tax ID Type
1428	FTX257	FTX.007.257	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text
1429	FTX258	FTX.007.258	CONTRACT-ID	Contract Identifier
1430	FTX259	FTX.007.259	PAYMENT-PERIOD-START-DATE	Payment Period Start Date
1431	FTX260	FTX.007.260	PAYMENT-PERIOD-END-DATE	Payment Period End Date
1432	FTX261	FTX.007.261	PAYMENT-PERIOD-TYPE	Payment Period Type
1433	FTX262	FTX.007.262	PAYMENT-PERIOD-TYPE-OTHER-TEXT	Payment Period Type Other Text

1434	FTX263	FTX.007.263	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
1435	FTX266	FTX.007.266	MBESCBES-FORM-GROUP	MBESCBES Form Group
1436	FTX265	FTX.007.265	MBESCBES-FORM	MBESCBES Form
1437	FTX264	FTX.007.264	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service
1438	FTX267	FTX.007.267	WAIVER-ID	Waiver ID

1439	FTX268	FTX.007.268	WAIVER-TYPE	Waiver Type
1440	FTX269	FTX.007.269	FUNDING-CODE	Funding Code
1441	FTX270	FTX.007.270	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share
1442	FTX271	FTX.007.271	SOURCE-LOCATION	Source Location
1443	FTX272	FTX.007.272	SPA-NUMBER	SPA Number
1444	FTX273	FTX.007.273	PAYMENT-CAT-XREF	Payment Cat Xref
1445	FTX274	FTX.007.274	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type
1446	FTX275	FTX.007.275	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text
1447	FTX276	FTX.007.276	MEMO	Memo

1448	FTX277	FTX.007.277	STATE-NOTATION	State Notation
1449	FTX279	FTX.008.279	RECORD-ID	Record ID
1450	FTX280	FTX.008.280	SUBMITTING-STATE	Submitting State
1451	FTX281	FTX.008.281	RECORD-NUMBER	Record Number
1452	FTX282	FTX.008.282	ICN-ORIG	Original ICN
1453	FTX283	FTX.008.283	ICN-ADJ	Adjustment ICN
1454	FTX285	FTX.008.285	ADJUSTMENT-IND	Adjustment Indicator
1455	FTX286	FTX.008.286	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date
1456	FTX287	FTX.008.287	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount
1457	FTX288	FTX.008.288	CHECK-EFF-DATE	Check Effective Date

1458	FTX289	FTX.008.289	CHECK-NUM	Check Number
1459	FTX290	FTX.008.290	PAYER-ID	Payer ID
1460	FTX291	FTX.008.291	PAYER-ID-TYPE	Payer ID Type
1461	FTX292	FTX.008.292	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text
1462	FTX293	FTX.008.293	PAYEE-ID	Payee Identifier

1463	FTX294	FTX.008.294	PAYEE-ID-TYPE	Payee Identifier Type
1464	FTX295	FTX.008.295	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text
1465	FTX296	FTX.008.296	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type
1466	FTX297	FTX.008.297	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text
1467	FTX298	FTX.008.298	PAYEE-TAX-ID	Payee Tax ID
1468	FTX299	FTX.008.299	PAYEE-TAX-ID-TYPE	Payee Tax ID Type
1469	FTX300	FTX.008.300	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text
1470	FTX301	FTX.008.301	COST-SETTLEMENT-PERIOD-START-DATE	Cost Settlement Period Start Date

1471	FTX302	FTX.008.302	COST-SETTLEMENT-PERIOD-END-DATE	Cost Settlement Period End Date
1472	FTX303	FTX.008.303	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
1473	FTX306	FTX.008.306	MBESCBES-FORM-GROUP	MBESCBES Form Group
1474	FTX305	FTX.008.305	MBESCBES-FORM	MBESCBES Form
1475	FTX304	FTX.008.304	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service

1476	FTX307	FTX.008.307	WAIVER-ID	Waiver ID
1477	FTX308	FTX.008.308	WAIVER-TYPE	Waiver Type
1478	FTX309	FTX.008.309	FUNDING-CODE	Funding Code
1479	FTX310	FTX.008.310	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share
1480	FTX311	FTX.008.311	SOURCE-LOCATION	Source Location
1481	FTX312	FTX.008.312	SPA-NUMBER	SPA Number
1482	FTX313	FTX.008.313	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type

1483	FTX314	FTX.008.314	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text
1484	FTX315	FTX.008.315	MEMO	Memo
1485	FTX316	FTX.008.316	STATE-NOTATION	State Notation
1486	FTX318	FTX.009.318	RECORD-ID	Record ID
1487	FTX319	FTX.009.319	SUBMITTING-STATE	Submitting State
1488	FTX320	FTX.009.320	RECORD-NUMBER	Record Number
1489	FTX321	FTX.009.321	ICN-ORIG	Original ICN
1490	FTX322	FTX.009.322	ICN-ADJ	Adjustment ICN
1491	FTX324	FTX.009.324	ADJUSTMENT-IND	Adjustment Indicator
1492	FTX325	FTX.009.325	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date
1493	FTX326	FTX.009.326	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount

1494	FTX327	FTX.009.327	CHECK-EFF-DATE	Check Effective Date
1495	FTX328	FTX.009.328	CHECK-NUM	Check Number
1496	FTX329	FTX.009.329	PAYER-ID	Payer ID
1497	FTX330	FTX.009.330	PAYER-ID-TYPE	Payer ID Type
1498	FTX331	FTX.009.331	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text
1499	FTX332	FTX.009.332	PAYEE-ID	Payee Identifier

1500	FTX333	FTX.009.333	PAYEE-ID-TYPE	Payee Identifier Type
1501	FTX334	FTX.009.334	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text
1502	FTX335	FTX.009.335	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type
1503	FTX336	FTX.009.336	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text
1504	FTX337	FTX.009.337	PAYEE-TAX-ID	Payee Tax ID
1505	FTX338	FTX.009.338	PAYEE-TAX-ID-TYPE	Payee Tax ID Type
1506	FTX339	FTX.009.339	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text
1507	FTX340	FTX.009.340	WRAP-PERIOD-START-DATE	Wrap Period Start Date

1508	FTX341	FTX.009.341	WRAP-PERIOD-END-DATE	Wrap Period End Date
1509	FTX342	FTX.009.342	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
1510	FTX345	FTX.009.345	MBESCBES-FORM-GROUP	MBESCBES Form Group
1511	FTX344	FTX.009.344	MBESCBES-FORM	MBESCBES Form
1512	FTX343	FTX.009.343	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service

1513	FTX346	FTX.009.346	WAIVER-ID	Waiver ID
1514	FTX347	FTX.009.347	WAIVER-TYPE	Waiver Type
1515	FTX348	FTX.009.348	FUNDING-CODE	Funding Code
1516	FTX349	FTX.009.349	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share
1517	FTX350	FTX.009.350	SOURCE-LOCATION	Source Location
1518	FTX351	FTX.009.351	SPA-NUMBER	SPA Number
1519	FTX352	FTX.009.352	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type

1520	FTX353	FTX.009.353	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text
1521	FTX354	FTX.009.354	MEMO	Memo
1522	FTX355	FTX.009.355	STATE-NOTATION	State Notation
1523	FTX357	FTX.095.357	RECORD-ID	Record ID
1524	FTX358	FTX.095.358	SUBMITTING-STATE	Submitting State
1525	FTX359	FTX.095.359	RECORD-NUMBER	Record Number
1526	FTX360	FTX.095.360	ICN-ORIG	Original ICN
1527	FTX361	FTX.095.361	ICN-ADJ	Adjustment ICN
1528	FTX363	FTX.095.363	ADJUSTMENT-IND	Adjustment Indicator
1529	FTX364	FTX.095.364	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date
1530	FTX365	FTX.095.365	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount

1531	FTX366	FTX.095.366	CHECK-EFF-DATE	Check Effective Date
1532	FTX367	FTX.095.367	CHECK-NUM	Check Number
1533	FTX368	FTX.095.368	PAYER-ID	Payer ID
1534	FTX369	FTX.095.369	PAYER-ID-TYPE	Payer ID Type
1535	FTX370	FTX.095.370	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text
1536	FTX371	FTX.095.371	PAYER-MCR-PLAN-TYPE	Payer MCR Plan Type
1537	FTX372	FTX.095.372	PAYER-MCR-PLAN-TYPE-OTHER-TEXT	Payer MCR Plan Type Other Text
1538	FTX373	FTX.095.373	PAYEE-ID	Payee Identifier

1539	FTX374	FTX.095.374	PAYEE-ID-TYPE	Payee Identifier Type
1540	FTX375	FTX.095.375	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text
1541	FTX376	FTX.095.376	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type
1542	FTX377	FTX.095.377	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text
1543	FTX378	FTX.095.378	PAYEE-TAX-ID	Payee Tax ID
1544	FTX379	FTX.095.379	PAYEE-TAX-ID-TYPE	Payee Tax ID Type
1545	FTX380	FTX.095.380	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text
1546	FTX381	FTX.095.381	CONTRACT-ID	Contract Identifier
1547	FTX382	FTX.095.382	INSURANCE-CARRIER-ID-NUM	Insurance Carrier Identification Number

1548	FTX383	FTX.095.383	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1549	FTX384	FTX.095.384	PAYMENT-PERIOD-START-DATE	Payment Period Start Date
1550	FTX385	FTX.095.385	PAYMENT-PERIOD-END-DATE	Payment Period End Date
1551	FTX386	FTX.095.386	PAYMENT-PERIOD-TYPE	Payment Period Type
1552	FTX387	FTX.095.387	PAYMENT-PERIOD-TYPE-OTHER-TEXT	Payment Period Type Other Text
1553	FTX388	FTX.095.388	TRANSACTION-TYPE	Transaction Type
1554	FTX389	FTX.095.389	TRANSACTION-TYPE-OTHER-TEXT	Transaction Type Other Text
1555	FTX390	FTX.095.390	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement
1556	FTX393	FTX.095.393	MBESCBES-FORM-GROUP	MBESCBES Form Group

1557	FTX392	FTX.095.392	MBESCBES-FORM	MBESCBES Form
1558	FTX391	FTX.095.391	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service
1559	FTX394	FTX.095.394	WAIVER-ID	Waiver ID
1560	FTX395	FTX.095.395	WAIVER-TYPE	Waiver Type
1561	FTX396	FTX.095.396	FUNDING-CODE	Funding Code

1562	FTX397	FTX.095.397	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share
1563	FTX398	FTX.095.398	SDP-IND	State Directed Payment Indicator
1564	FTX399	FTX.095.399	SOURCE-LOCATION	Source Location
1565	FTX400	FTX.095.400	SPA-NUMBER	SPA Number
1566	FTX401	FTX.095.401	PAYMENT-CAT-XREF	Payment Cat Xref
1567	FTX402	FTX.095.402	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type
1568	FTX403	FTX.095.403	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text
1569	FTX404	FTX.095.404	MEMO	Memo
1570	FTX405	FTX.095.405	STATE-NOTATION	State Notation

1571	MCR001	MCR.001.001	RECORD-ID	Record ID
1572	MCR002	MCR.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version
1573	MCR003	MCR.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type
1574	MCR004	MCR.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification
1575	MCR005	MCR.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version
1576	MCR006	MCR.001.006	FILE-NAME	File Name
1577	MCR007	MCR.001.007	SUBMITTING-STATE	Submitting State
1578	MCR008	MCR.001.008	DATE-FILE-CREATED	Date File Created
1579	MCR009	MCR.001.009	START-OF-TIME-PERIOD	Start of Time Period
1580	MCR010	MCR.001.010	END-OF-TIME-PERIOD	End of Time Period

1581	MCR011	MCR.001.011	FILE-STATUS-INDICATOR	File Status Indicator
1582	MCR013	MCR.001.013	TOT-REC-CNT	Total Record Count
1583	MCR113	MCR.001.113	FILE-SUBMISSION-METHOD	File Submission Method
1584	MCR112	MCR.001.112	SEQUENCE-NUMBER	Sequence Number
1585	MCR014	MCR.001.014	STATE-NOTATION	State Notation
1586	MCR016	MCR.002.016	RECORD-ID	Record ID
1587	MCR017	MCR.002.017	SUBMITTING-STATE	Submitting State
1588	MCR018	MCR.002.018	RECORD-NUMBER	Record Number
1589	MCR019	MCR.002.019	STATE-PLAN-ID-NUM	State Plan ID Number
1590	MCR020	MCR.002.020	MANAGED-CARE-CONTRACT-EFF-DATE	Managed Care Contract Effective Date

1591	MCR021	MCR.002.021	MANAGED-CARE-CONTRACT-END-DATE	Managed Care Contract End Date
1592	MCR022	MCR.002.022	MANAGED-CARE-NAME	Managed Care Name
1593	MCR023	MCR.002.023	MANAGED-CARE-PROGRAM	Managed Care Program
1594	MCR024	MCR.002.024	MANAGED-CARE-PLAN-TYPE	Managed Care Plan Type
1595	MCR025	MCR.002.025	REIMBURSEMENT-ARRANGEMENT	Reimbursement Arrangement
1596	MCR026	MCR.002.026	MANAGED-CARE-PROFIT-STATUS	Managed Care Profit Status

1597	MCR027	MCR.002.027	CORE-BASED-STATISTICAL-AREA-CODE	Core Based Statistical Area Code
1598	MCR028	MCR.002.028	PERCENT-BUSINESS	Percent Business
1599	MCR029	MCR.002.029	MANAGED-CARE-SERVICE-AREA	Managed Care Service Area
1600	MCR030	MCR.002.030	MANAGED-CARE-MAIN-REC-EFF-DATE	Managed Care Main Record Effective Date

1601	MCR031	MCR.002.031	MANAGED-CARE-MAIN-REC-END-DATE	Managed Care Main Record End Date
1602	MCR032	MCR.002.032	STATE-NOTATION	State Notation
1603	MCR034	MCR.003.034	RECORD-ID	Record ID
1604	MCR035	MCR.003.035	SUBMITTING-STATE	Submitting State
1605	MCR036	MCR.003.036	RECORD-NUMBER	Record Number
1606	MCR037	MCR.003.037	STATE-PLAN-ID-NUM	State Plan ID Number
1607	MCR038	MCR.003.038	MANAGED-CARE-LOCATION-ID	Managed Care Location ID
1608	MCR039	MCR.003.039	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-EFF-DATE	Managed Care Location and Contract Effective Date
1609	MCR040	MCR.003.040	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-END-DATE	Managed Care Location and Contract End Date
1610	MCR041	MCR.003.041	MANAGED-CARE-ADDR-TYPE	Managed Care Address Type

1611	MCR042	MCR.003.042	MANAGED-CARE-ADDR-LN1	Managed Care Address Line 1
1612	MCR043	MCR.003.043	MANAGED-CARE-ADDR-LN2	Managed Care Address Line 2
1613	MCR044	MCR.003.044	MANAGED-CARE-ADDR-LN3	Managed Care Address Line 3
1614	MCR045	MCR.003.045	MANAGED-CARE-CITY	Managed Care City
1615	MCR046	MCR.003.046	MANAGED-CARE-STATE	Managed Care State
1616	MCR047	MCR.003.047	MANAGED-CARE-ZIP-CODE	Managed Care ZIP Code
1617	MCR048	MCR.003.048	MANAGED-CARE-COUNTY	Managed Care County
1618	MCR049	MCR.003.049	MANAGED-CARE-TELEPHONE	Managed Care Phone Number
1619	MCR050	MCR.003.050	MANAGED-CARE-EMAIL	Managed Care Email
1620	MCR051	MCR.003.051	MANAGED-CARE-FAX-NUMBER	Managed Care Fax Number

1621	MCR052	MCR.003.052	STATE-NOTATION	State Notation
1622	MCR054	MCR.004.054	RECORD-ID	Record ID
1623	MCR055	MCR.004.055	SUBMITTING-STATE	Submitting State
1624	MCR056	MCR.004.056	RECORD-NUMBER	Record Number
1625	MCR057	MCR.004.057	STATE-PLAN-ID-NUM	State Plan ID Number
1626	MCR058	MCR.004.058	MANAGED-CARE-SERVICE-AREA-NAME	Managed Care Service Area Name
1627	MCR059	MCR.004.059	MANAGED-CARE-SERVICE-AREA-EFF-DATE	Managed Care Service Area Effective Date

1628	MCR060	MCR.004.060	MANAGED-CARE-SERVICE-AREA-END-DATE	Managed Care Service Area End Date
1629	MCR061	MCR.004.061	STATE-NOTATION	State Notation
1630	MCR063	MCR.005.063	RECORD-ID	Record ID
1631	MCR064	MCR.005.064	SUBMITTING-STATE	Submitting State
1632	MCR065	MCR.005.065	RECORD-NUMBER	Record Number
1633	MCR066	MCR.005.066	STATE-PLAN-ID-NUM	State Plan ID Number
1634	MCR067	MCR.005.067	OPERATING-AUTHORITY	Operating Authority
1635	MCR068	MCR.005.068	WAIVER-ID	Waiver ID
1636	MCR069	MCR.005.069	MANAGED-CARE-OP-AUTHORITY-EFF-DATE	Managed Care Op Authority Effective Date

1637	MCR070	MCR.005.070	MANAGED-CARE-OP-AUTHORITY-END-DATE	Managed Care Op Authority End Date
1638	MCR071	MCR.005.071	STATE-NOTATION	State Notation
1639	MCR073	MCR.006.073	RECORD-ID	Record ID
1640	MCR074	MCR.006.074	SUBMITTING-STATE	Submitting State
1641	MCR075	MCR.006.075	RECORD-NUMBER	Record Number
1642	MCR076	MCR.006.076	STATE-PLAN-ID-NUM	State Plan ID Number
1643	MCR077	MCR.006.077	MANAGED-CARE-PLAN-POP	Managed Care Plan Population
1644	MCR078	MCR.006.078	MANAGED-CARE-PLAN-POP-EFF-DATE	Managed Care Plan Population Effective Date
1645	MCR079	MCR.006.079	MANAGED-CARE-PLAN-POP-END-DATE	Managed Care Plan Population End Date
1646	MCR080	MCR.006.080	STATE-NOTATION	State Notation

1647	MCR082	MCR.007.082	RECORD-ID	Record ID
1648	MCR083	MCR.007.083	SUBMITTING-STATE	Submitting State
1649	MCR084	MCR.007.084	RECORD-NUMBER	Record Number
1650	MCR085	MCR.007.085	STATE-PLAN-ID-NUM	State Plan ID Number
1651	MCR086	MCR.007.086	ACCREDITATION-ORGANIZATION	Accreditation Organization
1652	MCR087	MCR.007.087	DATE-ACCREDITATION-ACHIEVED	Date Accreditation Achieved
1653	MCR088	MCR.007.088	DATE-ACCREDITATION-END	Date Accreditation End
1654	MCR089	MCR.007.089	STATE-NOTATION	State Notation
1655	MCR114	MCR.010.114	RECORD-ID	Record ID
1656	MCR115	MCR.010.115	SUBMITTING-STATE	Submitting State

1657	MCR116	MCR.010.116	RECORD-NUMBER	Record Number
1658	MCR117	MCR.010.117	STATE-PLAN-ID-NUM	State Plan ID Number
1659	MCR118	MCR.010.118	MANAGED-CARE-PLAN-OTHER-ID-TYPE	Managed Care Plan Other ID Type
1660	MCR119	MCR.010.119	MANAGED-CARE-PLAN-OTHER-ID	Managed Care Plan Other ID
1661	MCR120	MCR.010.120	MANAGED-CARE-ID-EFF-DATE	Managed Care ID Effective Date
1662	MCR121	MCR.010.121	MANAGED-CARE-ID-END-DATE	Managed Care ID End Date
1663	MCR122	MCR.010.122	STATE-NOTATION	State Notation
1664	PRV001	PRV.001.001	RECORD-ID	Record ID
1665	PRV002	PRV.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version
1666	PRV003	PRV.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type
1667	PRV004	PRV.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification
1668	PRV005	PRV.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version

1669	PRV006	PRV.001.006	FILE-NAME	File Name
1670	PRV007	PRV.001.007	SUBMITTING-STATE	Submitting State
1671	PRV008	PRV.001.008	DATE-FILE-CREATED	Date File Created
1672	PRV009	PRV.001.009	START-OF-TIME-PERIOD	Start of Time Period
1673	PRV010	PRV.001.010	END-OF-TIME-PERIOD	End of Time Period
1674	PRV011	PRV.001.011	FILE-STATUS-INDICATOR	File Status Indicator
1675	PRV013	PRV.001.013	TOT-REC-CNT	Total Record Count
1676	PRV139	PRV.001.139	FILE-SUBMISSION-METHOD	File Submission Method
1677	PRV138	PRV.001.138	SEQUENCE-NUMBER	Sequence Number

1678	PRV014	PRV.001.014	STATE-NOTATION	State Notation
1679	PRV016	PRV.002.016	RECORD-ID	Record ID
1680	PRV017	PRV.002.017	SUBMITTING-STATE	Submitting State
1681	PRV018	PRV.002.018	RECORD-NUMBER	Record Number
1682	PRV019	PRV.002.019	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID
1683	PRV020	PRV.002.020	PROV-ATTRIBUTES-EFF-DATE	Provider Attributes Effective Date
1684	PRV021	PRV.002.021	PROV-ATTRIBUTES-END-DATE	Provider Attributes End Date
1685	PRV022	PRV.002.022	PROV-DOING-BUSINESS-AS-NAME	Provider DBA Name
1686	PRV023	PRV.002.023	PROV-LEGAL-NAME	Provider Legal Name
1687	PRV024	PRV.002.024	PROV-ORGANIZATION-NAME	Provider Organization Name

1688	PRV025	PRV.002.025	PROV-TAX-NAME	Provider Tax Name
1689	PRV026	PRV.002.026	FACILITY-GROUP-INDIVIDUAL-CODE	Facility Group Individual Code
1690	PRV027	PRV.002.027	TEACHING-IND	Teaching Indicator
1691	PRV028	PRV.002.028	PROV-FIRST-NAME	Provider First Name
1692	PRV029	PRV.002.029	PROV-MIDDLE-INITIAL	Provider Middle Initial
1693	PRV030	PRV.002.030	PROV-LAST-NAME	Provider Last Name
1694	PRV031	PRV.002.031	SEX	Sex
1695	PRV032	PRV.002.032	OWNERSHIP-CODE	Ownership Code

1696	PRV033	PRV.002.033	PROV-PROFIT-STATUS	Provider Profit Status
1697	PRV034	PRV.002.034	DATE-OF-BIRTH	Date of Birth
1698	PRV035	PRV.002.035	DATE-OF-DEATH	Date of Death
1699	PRV036	PRV.002.036	ACCEPTING-NEW-PATIENTS-IND	Accepting New Patients Indicator
1700	PRV140	PRV.002.140	ATYPICAL-PROV-IND	Atypical Provider Indicator
1701	PRV037	PRV.002.037	STATE-NOTATION	State Notation
1702	PRV039	PRV.003.039	RECORD-ID	Record ID
1703	PRV040	PRV.003.040	SUBMITTING-STATE	Submitting State
1704	PRV041	PRV.003.041	RECORD-NUMBER	Record Number
1705	PRV042	PRV.003.042	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID

1706	PRV043	PRV.003.043	PROV-LOCATION-ID	Provider Location ID
1707	PRV044	PRV.003.044	PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE	Provider Location and Contact Info Effective Date
1708	PRV045	PRV.003.045	PROV-LOCATION-AND-CONTACT-INFO-END-DATE	Provider Location and Contact Info End Date
1709	PRV046	PRV.003.046	PROV-ADDR-TYPE	Provider Address Type
1710	PRV047	PRV.003.047	ADDR-LN1	Provider Address Line 1
1711	PRV048	PRV.003.048	ADDR-LN2	Provider Address Line 2
1712	PRV049	PRV.003.049	ADDR-LN3	Provider Address Line 3
1713	PRV050	PRV.003.050	ADDR-CITY	Provider City

1714	PRV051	PRV.003.051	ADDR-STATE	Provider State
1715	PRV052	PRV.003.052	ADDR-ZIP-CODE	Provider ZIP Code
1716	PRV053	PRV.003.053	ADDR-TELEPHONE	Provider Phone Number
1717	PRV054	PRV.003.054	ADDR-EMAIL	Provider Address Email
1718	PRV055	PRV.003.055	ADDR-FAX-NUM	Provider Address Fax
1719	PRV056	PRV.003.056	ADDR-BORDER-STATE-IND	Address Border State Indicator
1720	PRV057	PRV.003.057	ADDR-COUNTY	Provider County Code
1721	PRV058	PRV.003.058	STATE-NOTATION	State Notation
1722	PRV060	PRV.004.060	RECORD-ID	Record ID
1723	PRV061	PRV.004.061	SUBMITTING-STATE	Submitting State
1724	PRV062	PRV.004.062	RECORD-NUMBER	Record Number

1725	PRV063	PRV.004.063	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID
1726	PRV064	PRV.004.064	PROV-LOCATION-ID	Provider Location ID
1727	PRV065	PRV.004.065	PROV-LICENSE-EFF-DATE	Provider License Effective Date
1728	PRV066	PRV.004.066	PROV-LICENSE-END-DATE	Provider License End Date
1729	PRV067	PRV.004.067	LICENSE-TYPE	License Type
1730	PRV068	PRV.004.068	LICENSE-ISSUING-ENTITY-ID	License Issuing Entity ID

1731	PRV069	PRV.004.069	LICENSE-OR-ACCREDITATION-NUMBER	License or Accreditation Number
1732	PRV070	PRV.004.070	STATE-NOTATION	State Notation
1733	PRV072	PRV.005.072	RECORD-ID	Record ID
1734	PRV073	PRV.005.073	SUBMITTING-STATE	Submitting State
1735	PRV074	PRV.005.074	RECORD-NUMBER	Record Number
1736	PRV075	PRV.005.075	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID
1737	PRV076	PRV.005.076	PROV-LOCATION-ID	Provider Location ID
1738	PRV077	PRV.005.077	PROV-IDENTIFIER-TYPE	Provider Identifier Type

1739	PRV078	PRV.005.078	PROV-IDENTIFIER-ISSUING-ENTITY-ID	Provider Identifier Issuing Entity ID
1740	PRV079	PRV.005.079	PROV-IDENTIFIER-EFF-DATE	Provider Identifier Effective Date
1741	PRV080	PRV.005.080	PROV-IDENTIFIER-END-DATE	Provider Identifier End Date
1742	PRV081	PRV.005.081	PROV-IDENTIFIER	Provider Identifier
1743	PRV082	PRV.005.082	STATE-NOTATION	State Notation
1744	PRV084	PRV.006.084	RECORD-ID	Record ID

1745	PRV085	PRV.006.085	SUBMITTING-STATE	Submitting State
1746	PRV086	PRV.006.086	RECORD-NUMBER	Record Number
1747	PRV087	PRV.006.087	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID
1748	PRV088	PRV.006.088	PROV-CLASSIFICATION-TYPE	Provider Classification Type
1749	PRV089	PRV.006.089	PROV-CLASSIFICATION-CODE	Provider Classification Code
1750	PRV090	PRV.006.090	PROV-TAXONOMY-CLASSIFICATION-EFF-DATE	Provider Taxonomy Classification Effective Date
1751	PRV091	PRV.006.091	PROV-TAXONOMY-CLASSIFICATION-END-DATE	Provider Taxonomy Classification End Date
1752	PRV092	PRV.006.092	STATE-NOTATION	State Notation

1753	PRV094	PRV.007.094	RECORD-ID	Record ID
1754	PRV095	PRV.007.095	SUBMITTING-STATE	Submitting State
1755	PRV096	PRV.007.096	RECORD-NUMBER	Record Number
1756	PRV097	PRV.007.097	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID
1757	PRV098	PRV.007.098	PROV-MEDICAID-EFF-DATE	Provider Medicaid Effective Date
1758	PRV099	PRV.007.099	PROV-MEDICAID-END-DATE	Provider Medicaid End Date
1759	PRV100	PRV.007.100	PROV-MEDICAID-ENROLLMENT-STATUS-CODE	Provider Medicaid Enrollment Status Code
1760	PRV101	PRV.007.101	STATE-PLAN-ENROLLMENT	State Plan Enrollment
1761	PRV102	PRV.007.102	PROV-ENROLLMENT-METHOD	Provider Enrollment Method
1762	PRV103	PRV.007.103	APPL-DATE	Application Date

1763	PRV104	PRV.007.104	STATE-NOTATION	State Notation
1764	PRV106	PRV.008.106	RECORD-ID	Record ID
1765	PRV107	PRV.008.107	SUBMITTING-STATE	Submitting State
1766	PRV108	PRV.008.108	RECORD-NUMBER	Record Number
1767	PRV109	PRV.008.109	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID
1768	PRV110	PRV.008.110	SUBMITTING-STATE-PROV-ID-OF-AFFILIATED-ENTITY	Submitting State Provider ID of Affiliated Entity
1769	PRV111	PRV.008.111	PROV-AFFILIATED-GROUP-EFF-DATE	Provider Affiliated Group Effective Date
1770	PRV112	PRV.008.112	PROV-AFFILIATED-GROUP-END-DATE	Provider Affiliated Group End Date
1771	PRV113	PRV.008.113	STATE-NOTATION	State Notation

1772	PRV115	PRV.009.115	RECORD-ID	Record ID
1773	PRV116	PRV.009.116	SUBMITTING-STATE	Submitting State
1774	PRV117	PRV.009.117	RECORD-NUMBER	Record Number
1775	PRV118	PRV.009.118	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID
1776	PRV119	PRV.009.119	AFFILIATED-PROGRAM-TYPE	Affiliated Program Type
1777	PRV120	PRV.009.120	AFFILIATED-PROGRAM-ID	Affiliated Program ID
1778	PRV121	PRV.009.121	PROV-AFFILIATED-PROGRAM-EFF-DATE	Provider Affiliated Program Effective Date
1779	PRV122	PRV.009.122	PROV-AFFILIATED-PROGRAM-END-DATE	Provider Affiliated Program End Date
1780	PRV123	PRV.009.123	STATE-NOTATION	State Notation

1781	PRV125	PRV.010.125	RECORD-ID	Record ID
1782	PRV126	PRV.010.126	SUBMITTING-STATE	Submitting State
1783	PRV127	PRV.010.127	RECORD-NUMBER	Record Number
1784	PRV128	PRV.010.128	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID
1785	PRV129	PRV.010.129	PROV-LOCATION-ID	Provider Location ID
1786	PRV130	PRV.010.130	BED-TYPE-EFF-DATE	Bed Type Effective Date
1787	PRV131	PRV.010.131	BED-TYPE-END-DATE	Bed Type End Date
1788	PRV134	PRV.010.134	BED-TYPE-CODE	Bed Type Code

1789	PRV135	PRV.010.135	BED-COUNT	Bed Count
1790	PRV136	PRV.010.136	STATE-NOTATION	State Notation
1791	TPL001	TPL.001.001	RECORD-ID	Record ID
1792	TPL002	TPL.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version
1793	TPL003	TPL.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type
1794	TPL004	TPL.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification
1795	TPL005	TPL.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version
1796	TPL006	TPL.001.006	FILE-NAME	File Name
1797	TPL007	TPL.001.007	SUBMITTING-STATE	Submitting State
1798	TPL008	TPL.001.008	DATE-FILE-CREATED	Date File Created

1799	TPL009	TPL.001.009	START-OF-TIME-PERIOD	Start of Time Period
1800	TPL010	TPL.001.010	END-OF-TIME-PERIOD	End of Time Period
1801	TPL011	TPL.001.011	FILE-STATUS-INDICATOR	File Status Indicator
1802	TPL012	TPL.001.012	SSN-INDICATOR	SSN Indicator
1803	TPL013	TPL.001.013	TOT-REC-CNT	Total Record Count
1804	TPL095	TPL.001.095	FILE-SUBMISSION-METHOD	File Submission Method
1805	TPL088	TPL.001.088	SEQUENCE-NUMBER	Sequence Number
1806	TPL014	TPL.001.014	STATE-NOTATION	State Notation
1807	TPL016	TPL.002.016	RECORD-ID	Record ID

1808	TPL017	TPL.002.017	SUBMITTING-STATE	Submitting State
1809	TPL018	TPL.002.018	RECORD-NUMBER	Record Number
1810	TPL019	TPL.002.019	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1811	TPL020	TPL.002.020	TPL-HEALTH-INSURANCE-COVERAGE-IND	TPL Health Insurance Coverage Indicator
1812	TPL021	TPL.002.021	TPL-OTHER-COVERAGE-IND	TPL Other Coverage Indicator
1813	TPL022	TPL.002.022	ELIGIBLE-FIRST-NAME	Eligible First Name
1814	TPL023	TPL.002.023	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial
1815	TPL024	TPL.002.024	ELIGIBLE-LAST-NAME	Eligible Last Name
1816	TPL025	TPL.002.025	ELIG-PRSN-MAIN-EFF-DATE	Eligible Person Main Effective Date

1817	TPL026	TPL.002.026	ELIG-PRSN-MAIN-END-DATE	Eligible Person Main End Date
1818	TPL027	TPL.002.027	STATE-NOTATION	State Notation
1819	TPL029	TPL.003.029	RECORD-ID	Record ID
1820	TPL030	TPL.003.030	SUBMITTING-STATE	Submitting State
1821	TPL031	TPL.003.031	RECORD-NUMBER	Record Number
1822	TPL032	TPL.003.032	MSIS-IDENTIFICATION-NUM	MSIS Identification Number
1823	TPL033	TPL.003.033	INSURANCE-CARRIER-ID-NUM	Insurance Carrier ID Number
1824	TPL034	TPL.003.034	INSURANCE-PLAN-ID	Insurance Plan ID

1825	TPL035	TPL.003.035	GROUP-NUM	Group Number
1826	TPL036	TPL.003.036	MEMBER-ID	Member ID
1827	TPL037	TPL.003.037	INSURANCE-PLAN-TYPE	Insurance Plan Type
1828	TPL038	TPL.003.038	ANNUAL-DEDUCTIBLE-AMT	Annual Deductible Amount
1829	TPL044	TPL.003.044	POLICY-OWNER-FIRST-NAME	Policy Owner First Name
1830	TPL045	TPL.003.045	POLICY-OWNER-LAST-NAME	Policy Owner Last Name
1831	TPL046	TPL.003.046	POLICY-OWNER-SSN	Policy Owner SSN
1832	TPL047	TPL.003.047	POLICY-OWNER-CODE	Policy Owner Code
1833	TPL048	TPL.003.048	INSURANCE-COVERAGE-EFF-DATE	Insurance Coverage Effective Date
1834	TPL049	TPL.003.049	INSURANCE-COVERAGE-END-DATE	Insurance Coverage End Date

1835	TPL089	TPL.003.089	COVERAGE-TYPE	Coverage Type
1836	TPL050	TPL.003.050	STATE-NOTATION	State Notation
1837	TPL052	TPL.004.052	RECORD-ID	Record ID
1838	TPL053	TPL.004.053	SUBMITTING-STATE	Submitting State
1839	TPL054	TPL.004.054	RECORD-NUMBER	Record Number
1840	TPL055	TPL.004.055	INSURANCE-CARRIER-ID-NUM	Insurance Carrier ID Number
1841	TPL056	TPL.004.056	INSURANCE-PLAN-ID	Insurance Plan ID
1842	TPL057	TPL.004.057	INSURANCE-PLAN-TYPE	Insurance Plan Type
1843	TPL058	TPL.004.058	COVERAGE-TYPE	Coverage Type

1844	TPL059	TPL.004.059	INSURANCE-CATEGORIES-EFF-DATE	Insurance Categories Effective Date
1845	TPL060	TPL.004.060	INSURANCE-CATEGORIES-END-DATE	Insurance Categories End Date
1846	TPL061	TPL.004.061	STATE-NOTATION	State Notation
1847	TPL063	TPL.005.063	RECORD-ID	Record ID
1848	TPL064	TPL.005.064	SUBMITTING-STATE	Submitting State
1849	TPL065	TPL.005.065	RECORD-NUMBER	Record Number
1850	TPL066	TPL.005.066	MSIS-IDENTIFICATION-NUM	MSIS Identification Number

1851	TPL067	TPL.005.067	TYPE-OF-OTHER-THIRD-PARTY-LIABILITY	Type of Other TPL
1852	TPL068	TPL.005.068	OTHER-TPL-EFF-DATE	Other TPL Effective Date
1853	TPL069	TPL.005.069	OTHER-TPL-END-DATE	Other TPL End Date
1854	TPL070	TPL.005.070	STATE-NOTATION	State Notation
1855	TPL072	TPL.006.072	RECORD-ID	Record ID
1856	TPL073	TPL.006.073	SUBMITTING-STATE	Submitting State
1857	TPL074	TPL.006.074	RECORD-NUMBER	Record Number
1858	TPL075	TPL.006.075	INSURANCE-CARRIER-ID-NUM	Insurance Carrier ID Number
1859	TPL076	TPL.006.076	TPL-ENTITY-ADDR-TYPE	TPL Entity Address Type

1860	TPL077	TPL.006.077	INSURANCE-CARRIER-ADDR-LN1	Insurance Carrier Address Line 1
1861	TPL078	TPL.006.078	INSURANCE-CARRIER-ADDR-LN2	Insurance Carrier Address Line 2
1862	TPL079	TPL.006.079	INSURANCE-CARRIER-ADDR-LN3	Insurance Carrier Address Line 3
1863	TPL080	TPL.006.080	INSURANCE-CARRIER-CITY	Insurance Carrier City
1864	TPL081	TPL.006.081	INSURANCE-CARRIER-STATE	Insurance Carrier State
1865	TPL082	TPL.006.082	INSURANCE-CARRIER-ZIP-CODE	Insurance Carrier ZIP Code
1866	TPL083	TPL.006.083	INSURANCE-CARRIER-PHONE-NUM	Insurance Carrier Phone Number
1867	TPL084	TPL.006.084	TPL-ENTITY-CONTACT-INFO-EFF-DATE	TPL Entity Contact Info Effective Date
1868	TPL085	TPL.006.085	TPL-ENTITY-CONTACT-INFO-END-DATE	TPL Entity Contact Info End Date
1869	TPL090	TPL.006.090	INSURANCE-CARRIER-NAIC-CODE	Insurance Carrier NAIC Code

1870	TPL091	TPL.006.091	INSURANCE-CARRIER-NAME	Insurance Carrier Name
1871	TPL086	TPL.006.086	STATE-NOTATION	State Notation

transactions file type and associated segments are listed under "File Segment Number" heading

Data Element Necessity	Definition
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.
Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.
Mandatory	Denotes which supported file encoding standard was used to create the file.
Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file.

Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	The date on which the file was created.
Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.
Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.
Mandatory	A code to indicate whether the records in the file are test or production records.
Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.
Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.

Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.
Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.

Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.
Mandatory	This code denotes the type of hospital on the claim (servicing facility).
Conditional	In the claims files this data element indicates whether the claim or encounter was covered under the authority of an 1115A demonstration. In the Eligibility file, this data element indicates whether the individual participates in an 1115A demonstration.
Mandatory	Indicates the type of adjustment record.
Conditional	Claim adjustment reason codes communicate why a claim was paid differently than it was billed.
Mandatory	The basic types of admission for Inpatient hospital stays and a code indicating the priority of this admission.
Conditional	Description of the associated state-specific DRG code. If using standard MS-DRG classification system, leave blank.

Conditional	A code representing the Diagnosis Related Group (DRG) that is applicable for the inpatient services being rendered. This field is required on FFS claims and encounters records in which diagnosis related groups are used to determine paid amounts.
Conditional	An indicator identifying the grouping algorithm used to assign Diagnosis Related Group (DRG) values. Values are generated by combining two types of information: Position 1-2, State/Group generating DRG: If state specific system, fill with two digit US postal code representation for state. If CMS Grouper, fill with 'HG'. If any other system, fill with 'XX'. Position 3-4, fill with the number that represents the DRG version used (01-98). For example, 'HG15' would represent CMS Grouper version 15. If version is unknown, fill with '99'.
Conditional	A procedure code based on ICD-9 and ICD-10 used by the state to identify the procedures performed during the hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code1, Procedure Code Date-1, and Procedure Code Flag 1. The principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes. It is closely related to either the principal diagnosis or to complications that arise during other treatments. Use Procedure Code 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.
Conditional	A flag that identifies the coding system used for an associated procedure code.
Conditional	The date upon which a reported medical procedure was performed.

Conditional	A procedure code based on ICD-9 and ICD-10 used by the state to identify the procedures performed during the hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code 1, and Procedure Code Flag 1. The principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes. It is closely related to either the principal diagnosis or to complications that arise during other treatments. Use Procedure Code 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.
Conditional	A flag that identifies the coding system used for an associated procedure code.
Conditional	The date upon which a reported medical procedure was performed.
Conditional	A procedure code based on ICD-9 and ICD-10 used by the state to identify the procedures performed during the hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code Date 1, and Procedure Code Flag 1. The principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes. It is closely related to either the principal diagnosis or to complications that arise during other treatments. Use Procedure Code 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.
Conditional	A flag that identifies the coding system used for an associated procedure code.

Conditional	The date upon which a reported medical procedure was performed.
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Conditional	A flag that identifies the coding system used for an associated procedure code.
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Conditional	A flag that identifies the coding system used for an associated procedure code.
Conditional	The date upon which a reported medical procedure was performed.
Conditional	A procedure code based on ICD-9 and ICD-10 used by the state to identify the procedures performed during the hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code Date 1, and Procedure Code Flag 1. The principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes. It is closely related to either the principal diagnosis or to complications that arise during other treatments. Use Procedure Code 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.
Conditional	A flag that identifies the coding system used for an associated procedure code.
Conditional	The date upon which a reported medical procedure was performed.

Mandatory	The date on which the recipient was admitted to a hospital.
Conditional	The hour of admission to a hospital.
Conditional	The date on which the recipient was discharged from a hospital.
Conditional	The hour of discharge from a hospital.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3, C, W), the date the managed care organization paid the provider for the claim or adjustment.
Mandatory	A code to indicate what type of payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = "3" for a Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter record.

Mandatory	A data element corresponding with UB-04 form locator FL4 that classifies the claim as to the type of facility (2nd digit), type of care (3rd digit) and the billing record's sequence in the episode of care (4th digit). (Note that the 1st digit is always zero.)
Conditional	The health care claim status codes convey the status of an entire claim status codes from the 277 transaction set. Only report the claim status for the final, adjudicated claim.
Mandatory	The general category of the claim status (accepted, rejected, pended, finalized, additional information requested, etc.), which is then further detailed in the companion data element claim status.
Mandatory	The field denotes the claims payment system from which the claim was extracted. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report a SOURCE-LOCATION = '22' to indicate that the sub-capitated entity paid a provider for the service to the enrollee on a FFS basis. For sub-capitated encounters from a sub-capitated network provider that were submitted to sub-capitated entity, report a SOURCE-LOCATION = '23' to indicate that the sub-capitated network provider provided the service directly to the enrollee. For sub-capitated encounters from a sub-capitated network provider, report a SOURCE-LOCATION = “23” to indicate that the sub-capitated network provider provided the service directly to the enrollee.
Conditional	The check or electronic funds transfer number.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.

Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).
Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).
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Conditional	The total amount billed for this claim at the claim header level as submitted by the provider. For encounter records, when Type of Claim value is in [3, C, W], then value must equal amount the provider billed to the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the provider billed the sub-capitated entity for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The claim header level maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On FFS claims the Allowed Amount is determined by the state's MMIS. On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity allowed for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment at the claim header level, which is the sum of the amounts paid by Medicaid or the managed care plan at the detail level for the claim. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity paid the provider for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.

Conditional	The amount paid by Medicaid/CHIP, on this claim at the claim header level, toward the beneficiary's Medicare deductible. If the Medicare deductible amount can be identified separately from Medicare coinsurance payments, code that amount in this field. If the Medicare coinsurance and deductible payments cannot be separated, fill this field with the combined payment amount, code Medicare Combined Indicator a '1' and leave Total Medicare Coinsurance Amount unpopulated.
Conditional	The total amount paid by the Medicaid/CHIP agency or a managed care plan towards the portion of the Medicare allowed charges that Medicare applied to coinsurance.
Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim header level paid by the third party.
Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.
Conditional	The field denotes whether the insured party is covered under an other insurance plan other than Medicare or Medicaid.
Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.

Conditional	This indicator indicates that the reimbursement amount included on the claim is for a fixed payment. Fixed payments are made by the state to insurers or providers for premiums or eligible coverage, not for a particular service. For example, some states have Primary Care Case Management programs where the state pays providers a monthly patient management fee of $3.50 for each eligible participant under their care. This fee is considered a fixed payment. It is very important for states to correctly identify fixed payments. Fixed payments do not have a defined 'medical record' associated with the payment; therefore, fixed payments are not subject to medical record request and medical record review.
Conditional	A code to indicate the source of non-federal share funds.
Conditional	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Conditional	Code indicating that the amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare deductible was combined with their coinsurance amount because the amounts could not be separated.
Mandatory	A code to indicate special Medicaid program under which the service was provided.

Conditional	A unique number assigned by the state which represents a distinct comprehensive managed care plan, prepaid health plan, primary care case management program, a program for all-inclusive care for the elderly entity, or other approved plans.
Mandatory	The field denotes whether the payment amount was determined at the claim header or line/detail level. For claims where payment is NOT determined at the individual line level (PAYMENT-LEVEL-IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts are left blank and the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amount is reported at the header level only. For claims where payment/allowed amount is determined at the individual lines and when applicable, cost-sharing and/or coordination of benefits were deducted from one or more specific line-level payment/allowed amounts (PAYMENT-LEVEL-IND = 2), the allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the claim header. For claims where payment/allowed amount is determined at the individual lines but then cost sharing or coordination of benefits was deducted from the total paid/allowed amount at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-PAID-AMT) would be blank and line-level allowed (ALLOWED-AMT) and header level total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts must all be populated but the line level allowed amounts are not expected to sum exactly to the header level total allowed. For example, if a claim for an office visit and a procedure is assigned a separate line-level allowed amount for each line, but then at the header level a copay is deducted from the header-level total allowed and/or total paid amounts, then the sum of line-level allowed amounts may not be equal to the header-level total allowed amounts or correspond directly to the total paid amount. If the state cannot distinguish between the scenarios for value 1 and value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.
Conditional	A code to indicate the type of Medicare reimbursement.

Conditional	The number of days of inpatient care not covered by the payer for this sequence as qualified by the payer organization. The number of non-covered days does not refer to days not covered for any other service.
Conditional	The charges for inpatient care, which are not reimbursable by the primary payer. The non-covered charges do not refer to charges not covered for any other service.
Conditional	The number of days covered by Medicaid on this claim. For states that combine delivery/birth services on a single claim, include covered days for both the mother and the neonate in this field.
Mandatory	The total number of lines on the claim.
Conditional	Indicates if the claim was processed by forcing it through a manual override process.
Conditional	This code indicates whether the claim has a Health Care Acquired Condition. For additional coding information refer to the following site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/hospitalacqcond/05_Coding.asp#TopOfPage
Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.
Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.

Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.
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Conditional	The start date of the corresponding occurrence code or occurrence span codes.
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Conditional	The start date of the corresponding occurrence code or occurrence span codes.
Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.

Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.
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Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.
Conditional	The weight of a newborn at time of birth in grams (applicable to newborns only). The field is required when a claim involves a child birth.
Conditional	A patient's unique number assigned by the provider agency during claim submission, which identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment

Conditional	The last name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)
Conditional	The first name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)
Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).
Mandatory	Date of birth of the individual to whom the services were provided. A patient's age should not be greater than 112 years.
Conditional	Indicates whether the claim is submitted by a provider or provider group enrolled in the Health Home care model to provide services for the beneficiary on the claim. Health home providers provide service for patients with chronic illnesses. States that do not specify an eligible individual's health home provider number, if applicable, should not report claims that indicate the claim is submitted by a provider or provider group enrolled in the health home model.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which claim is submitted.
Conditional	Field specifying the waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.

Conditional	A unique identification number assigned by the state to a provider or managed care plan. This data element should represent the entity billing for the service. For encounter records, if associated Type of Claim value equals 3, C, or W, then value must be the state identifier of the provider or entity (billing or reporting) to the managed care plan.
Conditional	The National Provider ID (NPI) of the billing entity responsible for billing a patient for healthcare services. The billing provider can also be servicing, referring, or prescribing provider. Can be admitting provider except for Long Term Care.
Conditional	The taxonomy code for the institution billing for the beneficiary.
Conditional	A code to describe the type of provider being reported.
Conditional	This code describes the area of specialty for the provider being reported.
Conditional	The National Provider ID (NPI) of the doctor responsible for admitting a patient to a hospital or other inpatient health facility.
Conditional	The Medicaid ID of the doctor responsible for admitting a patient to a hospital or other inpatient health facility.
Conditional	This code describes the area of specialty for the provider being reported.

Conditional	Taxonomic classification (code) for a given healthcare provider, as defined by the National Uniform Claim Committee.
Conditional	A code to describe the type of provider being reported.
Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number is not available, but the physician's Drug Enforcement Agency (DEA) ID is on the State file, then the State should use the DEA ID for this data element.
Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.
Conditional	The additional payment on a claim that is associated with either a cost outlier or length of stay outlier. Outlier payments compensate hospitals paid on a fixed amount per Medicare 'diagnosis related group' discharge with extra dollars for patient stays that substantially exceed the typical requirements for patient stays in the same DRG category.
Conditional	The relative weight for the DRG on the claim. Each year CMS assigns a relative weight to each DRG. These weights indicate the relative costs for treating patients during the prior year. The national average charge for each DRG is compared to the overall average. This ratio is published annually in the Federal Register for each DRG. A DRG with a weight of 2.0000 means that charges were historically twice the average; a DRG with a weight of 0.5000 was half the average. This data element in T-MSIS is expected to capture the relative weight of the DRG in the state's system regardless of which DRG system the state uses.
Conditional	The Medicare HIC Number (HICN) is an identifier formerly used by SSA and CMS to identify all Medicare beneficiaries. For many beneficiaries, their SSN was a major component of their HICN. To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to be used by Medicare for limited administrative purposes after 2019 but starting in 2020 the MBI became the primary identifier for Medicare beneficiaries. HICN consists of two components: SSN and alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based).

Conditional	This code indicates the Type of Outlier Code or DRG Source. The field identifies two mutually exclusive conditions. The first, for PPS providers (codes 0, 1, and 2), classifies stays of exceptional cost or length (outliers). The second, for non-PPS providers (codes 6, 7, 8, and 9), denotes the source for developing the DRG. https://www.resdac.org/cms-data/variables/medpar-drgoutlier-stay-code
Conditional	This field specifies the number of days paid as outliers under Prospective Payment System (PPS) and the days over the threshold for the DRG.
Mandatory	A code indicating the patient's status as of the last day the claim covers. Values used are from UB-04. This is also referred to as patient discharge status. A valid list of codes can be purchased at: https://www.nubc.org/license
Mandatory	The Remittance Advice Number is a sequential number that identifies the current Remittance Advice (RA) produced for a provider. The number is incremented by one each time a new RA is generated. The RA is the detailed explanation of the reason for the payment amount.
Conditional	An indicator that denotes that claims in excess of a pre-determined number of claim lines (threshold determined by the individual state) will be split during processing.
Conditional	A code to indicate whether an individual received services or equipment across state borders. (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their coinsurance for the covered services on the claim. Do not include coinsurance payments made by a third party/s on behalf of the beneficiary.
Conditional	The date the beneficiary paid the coinsurance amount.
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on the claim. Do not include copayment payments made by a third party/s on behalf of the beneficiary.
Conditional	The date the beneficiary paid the copayment amount.

Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their deductible for the covered services on the claim. Do not include deductible payments made by a third party/s on behalf of the beneficiary.
Conditional	The date the beneficiary paid the deductible amount.
Mandatory	An indicator to identify a claim that the state refused pay in its entirety.
Situational	An indicator signifying that the copay was discounted or waived by the provider (e.g., physician or hospital). Do not use to indicate administrative-level, Medicaid State Agency or Medicaid MCO copayment waived decisions.
Conditional	A free-form text field to indicate the health home program that authorized payment for the service on the claim or to identify the health home SPA in which an individual is enrolled. The name entered should be the name that the state uses to uniquely identify the team. A "Health Home Entity" can be a designated provider (e.g., physician, clinic, behavioral health organization), a health team which links to a designated provider, or a health team (physicians, nurses, behavioral health professionals). Because an identification numbering schema has not been established, the entities' names are being used instead.
Situational	The amount of money paid by a third party on behalf of the beneficiary towards coinsurance.
Conditional	The date the third party paid the coinsurance amount
Situational	The amount of money paid by a third party on behalf of the beneficiary towards copayment.
Situational	The date the third party paid the copayment amount.

Conditional	The amount included in the Total Medicaid Amount (CIP.002.114) that is attributable to a Disproportionate Share Hospital (DSH) payment, when the state makes DSH payments by claim.
Conditional	The National Provider ID (NPI) of the health home provider.
Conditional	The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the MBI over the course of 2018 and 2019. Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.
Conditional	Taxonomic classification (code) for a given healthcare provider, as defined by the National Uniform Claim Committee.
Conditional	The amount paid by Medicare on this claim. For claims where Medicare payment is only available at the line level, report the sum of all the line level Medicare payment amounts at the header.

Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location and Contact Info (PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the PRV.004 or PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.
Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, this would be the date on which the service covered by this claim began.
Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended.
Conditional	The total copayment amount on a claim that the beneficiary is obligated to pay for covered services. This is the total Medicaid or contract negotiated beneficiary copayment liability for covered service on the claim. Do not subtract out any payments made toward the copayment.
Conditional	The total coinsurance amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for covered services on the claim. Do not subtract out any payments made toward the coinsurance.

Conditional	The total deductible amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability minus previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.
Conditional	The combined amounts the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment, coinsurance, and/or deductible for the covered services on the claim. Only report this data element when the claim does not differentiate among copayment, coinsurance, and/or deductible payments made by the beneficiary. Do not include beneficiary cost sharing payments made by a third party/ies on behalf of the beneficiary.
Conditional	The total amount paid by the patient for services where they are required to use their personal funds to cover part of their care before Medicaid funds can be utilized.
Mandatory	Billing provider address line 1 from X12 837I loop 2010AA.
Conditional	Billing provider address line 2 from X12 837I loop 2010AA.
Mandatory	Billing provider address city name from X12 837I loop 2010AA.
Mandatory	Billing provider address state code from X12 837I loop 2010AA.
Mandatory	Billing provider address ZIP code from X12 837I loop 2010AA.
Conditional	Service facility location organization NPI from X12 837I loop 2310E.
Conditional	Service facility location address line 1 from X12 837I loop 2310E.

Conditional	Service facility location address line 2 from X12 837I loop 2310E.
Conditional	Service facility location address city name from X12 837I loop 2310E.
Conditional	Service facility location address state code from X12 837I loop 2310E.
Conditional	Service facility location address ZIP code from X12 837I loop 2310E.
Mandatory	A code indicating the format in which the provider submitted their claim. Very few if any claims should be classified as "Other".
Conditional	A free-form text field where a state can identify the "other" claim form used by the provider to submit their claim. Required when "Other" is reported to Provider Claim Form Code.
Conditional	The amount included in the Total Medicaid Amount (CIP.002.114) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.
Conditional	The component (in dollar and cents) of the total allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Conditional	The component (in dollar and cents) of the total paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.
Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	A unique number to identify the transaction line number that is being reported on the original claim.

Conditional	A unique number to identify the transaction line number that identifies the line number on the adjustment claim.
Conditional	A code to indicate the type of adjustment record claim/encounter represents at claim detail level.
Conditional	Claim adjustment reason codes communicate why a service line was paid differently than it was billed.
Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.
Conditional	The claim line status codes from the 277 transaction set identify the status of a specific detail claim line rather than the entire claim. Only report the claim line for the final, adjudicated claim.
Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, this would be the date on which the service covered by this claim began.

Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended.
Mandatory	A code which identifies a specific accommodation, ancillary service or billing calculation (as defined by UB-04 Billing Manual). Revenue Code should be passed through to T-MSIS exactly as it was billed by the provider on the provider's 837I or UB-04 claim. It is only required on Inpatient, Long-Term Care and Other Fee for Service claims and managed care encounters that have a valid Type of Bill value. It's not required on financial transactions or non-institutional claims.
Mandatory	On facility claims/encounters, this field is to capture the actual service quantity by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood, etc. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed. For CLAIMOT claims/encounters use Service Quantity Actual and CLAIMRX claims/encounters use the Prescription Quantity Actual field
Conditional	On facility claims/encounters, this field is to capture maximum allowable quantity by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood, etc. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was allowed. This field is only applicable when the service being billed can be quantified in discrete units, e.g., a number of visits or the number of units of a prescription/refill that were filled. For CLAIMOT claims/encounters use Service Quantity Allowed and CLAIMRX claims/encounters use the Prescription Quantity Allowed field.

Conditional	The total amount billed for the related Revenue Code. Total amount billed includes both covered and non-covered charges (as defined by UB-04 Billing Manual). For encounter records, Type of Claim = 3, C, or W, this field should be populated with the amount that the provider billed to the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the provider billed the sub-capitated entity at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The maximum amount displayed at the claim line level as determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity allowed at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity paid the provider at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The amount that would have been paid had the services been provided on a Fee for Service basis.

Conditional	Unit of billing that is used for billing services by the facility.
Mandatory	A code to categorize the services provided to a Medicaid or CHIP enrollee.
Conditional	A unique number to identify the provider who treated the recipient. The Servicing Provider Number should be for the individual doctor who rendered the service. If "Servicing" provider and the "Billing" provider such as a sole-practitioner are the same then use the same number in both fields. The value is conditional as its usage varies by state.
Conditional	The NPI of the health care professional who delivers or completes a particular medical service or non-surgical procedure. The Servicing Provider NPI Number is required when rendering provider is different than the attending provider and state or federal regulatory requirements call for a "combined claim" (i.e., a claim that includes both facility and professional components). Examples are Medicaid clinic bills or critical access hospital claims.
Conditional	A code to describe the type of provider being reported.
Conditional	This code describes the area of specialty for the provider being reported.
Conditional	The National Provider ID (NPI) of the provider who performed the surgical procedures on the beneficiary.
Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.
Mandatory	The type of facility in which services on the claim were rendered. The Provider Facility Type code set is based on corresponding groups of HIPAA provider taxonomy codes.

Conditional	A code to indicate the Federal funding source for the payment.
Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.
Conditional	This field is to capture the actual quantity of the National Drug Code being prescribed on the claim/encounter.
Conditional	A code following the National Drug Code format indicating the drug, device, or medical supply covered by this claim.
Conditional	A code to indicate the basis by which the quantity of the National Drug Code is expressed.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	This data element is not applicable to this file type.
Conditional	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved. (Also referred to as a Prior Authorization or Referral Number).
Mandatory	To indicate Services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.
Conditional	An unique identifier assigned to every medical device that meets the requirements of 21 CFR 801 and 830.

Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.
Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.
Conditional	The amount included in the Medicaid Amount (CIP.003.254) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.

Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number is not available, but the physician's Drug Enforcement Agency (DEA) ID is on the State file, then the State should use the DEA ID for this data element.
Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.
Conditional	The component (in dollar and cents) of the allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Conditional	The component (in dollar and cents) of the paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.

Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	Indicates the context of the diagnosis code from the provider's claim (i.e., an 837I claim can have one principal diagnosis code, one admitting diagnosis code, up to 12 external cause of injury diagnosis codes, and up to 24 other diagnosis codes; a UB-04 claim can have one principal diagnosis code, one admitting diagnosis code, and up to 17 other diagnosis codes). The type of diagnosis code (e.g., principal, admitting, external cause of injury, or other) is captured here. The order in which the diagnosis code was reported is captured in the Diagnosis Sequence Number.
Mandatory	The order in which the diagnosis occurred on the provider's claim for a given type of diagnosis code (e.g., an 837I claim can have up to 12 external cause of injury diagnosis codes and up to 24 other diagnosis codes).
Mandatory	Flag used to identify wither the associated Diagnosis Code value is a ICD-9 or ICD-10 code.
Mandatory	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as '21051'.

Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.
Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.
Mandatory	Denotes which supported file encoding standard was used to create the file.
Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file.
Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.

Mandatory	The date on which the file was created.
Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.
Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.
Mandatory	A code to indicate whether the records in the file are test or production records.
Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.
Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.
Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.
Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/

Mandatory	An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.
Conditional	In the claims files this data element indicates whether the claim or encounter was covered under the authority of an 1115A demonstration. In the Eligibility file, this data element indicates whether the individual participates in an 1115A demonstration.
Mandatory	Indicates the type of adjustment record.
Conditional	Claim adjustment reason codes communicate why a claim was paid differently than it was billed.
Mandatory	The date on which the recipient was admitted to a psychiatric or long-term care facility.
Conditional	The time of admission to a psychiatric or long-term care facility.

Conditional	The date on which the recipient was discharged from a psychiatric or long-term care facility.
Conditional	The time of discharge from a psychiatric or long-term care facility.
Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, this would be the date on which the service covered by this claim began.
Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3, C, W), the date the managed care organization paid the provider for the claim or adjustment.

Mandatory	A code to indicate what type of payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = '3' for a Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter record.
Mandatory	A data element corresponding with UB-04 form locator FL4 that classifies the claim as to the type of facility (2nd digit), type of care (3rd digit) and the billing record's sequence in the episode of care (4th digit). (Note that the 1st digit is always zero.)
Conditional	The health care claim status codes convey the status of an entire claim status codes from the 277 transaction set. Only report the claim status for the final, adjudicated claim.
Mandatory	The general category of the claim status (accepted, rejected, pended, finalized, additional information requested, etc.) from the 277 transaction set which is then further detailed in the companion data element claim status.
Mandatory	The field denotes the claims payment system from which the claim was extracted. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report a SOURCE-LOCATION = '22' to indicate that the sub-capitated entity paid a provider for the service to the enrollee on a FFS basis. For sub-capitated encounters from a sub-capitated network provider that were submitted to sub-capitated entity, report a SOURCE-LOCATION = '23' to indicate that the sub-capitated network provider provided the service directly to the enrollee. For sub-capitated encounters from a sub-capitated network provider, report a SOURCE-LOCATION = “23” to indicate that the sub-capitated network provider provided the service directly to the enrollee.
Conditional	The check or electronic funds transfer number.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.

Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).
Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).
Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).
Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).

Conditional	The total amount billed for this claim at the claim header level as submitted by the provider. For encounter records, when Type of Claim value is in [3, C, W], then value must equal amount the provider billed to the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the provider billed the sub-capitated entity for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The claim header level maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On FFS claims the Allowed Amount is determined by the state's MMIS. On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity allowed for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment at the claim header level, which is the sum of the amounts paid by Medicaid or the managed care plan at the detail level for the claim. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity paid the provider for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.

Conditional	The amount paid by Medicaid/CHIP, on this claim at the claim header level, toward the beneficiary's Medicare deductible. If the Medicare deductible amount can be identified separately from Medicare coinsurance payments, code that amount in this field. If the Medicare coinsurance and deductible payments cannot be separated, fill this field with the combined payment amount, code Medicare Combined Indicator a '1' and leave Total Medicare Coinsurance Amount unpopulated.
Conditional	The total amount paid by the Medicaid/CHIP agency or a managed care plan towards the portion of the Medicare allowed charges that Medicare applied to coinsurance.
Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim header level paid by the third party.
Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.
Conditional	The field denotes whether the insured party is covered under an other insurance plan other than Medicare or Medicaid.
Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.

Conditional	This indicator indicates that the reimbursement amount included on the claim is for a fixed payment. Fixed payments are made by the state to insurers or providers for premiums or eligible coverage, not for a particular service. For example, some states have Primary Care Case Management programs where the state pays providers a monthly patient management fee of $3.50 for each eligible participant under their care. This fee is considered a fixed payment. It is very important for states to correctly identify fixed payments. Fixed payments do not have a defined 'medical record' associated with the payment; therefore, fixed payments are not subject to medical record request and medical record review.
Conditional	A code to indicate the source of non-federal share funds.
Conditional	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Conditional	Code indicating that the amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare deductible was combined with their coinsurance amount because the amounts could not be separated.
Mandatory	A code to indicate special Medicaid program under which the service was provided.

Conditional	A unique number assigned by the state which represents a distinct comprehensive managed care plan, prepaid health plan, primary care case management program, a program for all-inclusive care for the elderly entity, or other approved plans.
Mandatory	The field denotes whether the payment amount was determined at the claim header or line/detail level. For claims where payment is NOT determined at the individual line level (PAYMENT-LEVEL-IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts are left blank and the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amount is reported at the header level only. For claims where payment/allowed amount is determined at the individual lines and when applicable, cost-sharing and/or coordination of benefits were deducted from one or more specific line-level payment/allowed amounts (PAYMENT-LEVEL-IND = 2), the allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the claim header. For claims where payment/allowed amount is determined at the individual lines but then cost sharing or coordination of benefits was deducted from the total paid/allowed amount at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-PAID-AMT) would be blank and line-level allowed (ALLOWED-AMT) and header level total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts must all be populated but the line level allowed amounts are not expected to sum exactly to the header level total allowed. For example, if a claim for an office visit and a procedure is assigned a separate line-level allowed amount for each line, but then at the header level a copay is deducted from the header-level total allowed and/or total paid amounts, then the sum of line-level allowed amounts may not be equal to the header-level total allowed amounts or correspond directly to the total paid amount. If the state cannot distinguish between the scenarios for value 1 and value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.

Conditional	A code to indicate the type of Medicare reimbursement.
Conditional	The number of days of institutional long-term care not covered by the payer for this sequence as qualified by the payer organization. The number of non-covered days does not refer to days not covered for any other service.
Conditional	The charges for institutional long-term care, which are not reimbursable by the primary payer. The non-covered charges do not refer to charges not covered for any other service.
Conditional	The number of inpatient psychiatric days covered by Medicaid on this claim.
Mandatory	The total number of lines on the claim.
Conditional	Indicates if the claim was processed by forcing it through a manual override process.
Conditional	This code indicates whether the claim has a Health Care Acquired Condition. For additional coding information refer to the following site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/hospitalacqcond/05_Coding.asp#TopOfPage
Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.

Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.
Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.
Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.
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Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.
Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.
Conditional	The start date of the corresponding occurrence code or occurrence span codes.

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Conditional	The start date of the corresponding occurrence code or occurrence span codes.

Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.
Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.
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Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.
Conditional	A patient's unique number assigned by the provider agency during claim submission, which identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment

Conditional	The last name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)
Conditional	The first name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)
Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).
Mandatory	An individual's date of birth.
Conditional	Indicates whether the claim is submitted by a provider or provider group enrolled in the Health Home care model to provide services for the beneficiary on the claim. Health home providers provide service for patients with chronic illnesses. States that do not specify an eligible individual's health home provider number, if applicable, should not report claims that indicate the claim is submitted by a provider or provider group enrolled in the health home model.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which claim is submitted.
Conditional	Field specifying the waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.

Conditional	A unique identification number assigned by the state to a provider or managed care plan. This data element should represent the entity billing for the service. For encounter records, if associated Type of Claim value equals 3, C, or W, then value must be the state identifier of the provider or entity (billing or reporting) to the managed care plan.
Conditional	The National Provider ID (NPI) of the billing entity responsible for billing a patient for healthcare services. The billing provider can also be servicing, referring, or prescribing provider. Can be admitting provider except for Long Term Care.
Conditional	The taxonomy code for the institution billing for the beneficiary.
Conditional	A code to describe the type of provider being reported.
Conditional	This code describes the area of specialty for the provider being reported.
Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number is not available, but the physician's Drug Enforcement Agency (DEA) ID is on the State file, then the State should use the DEA ID for this data element.
Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.

Conditional	The Medicare HIC Number (HICN) is an identifier formerly used by SSA and CMS to identify all Medicare beneficiaries. For many beneficiaries, their SSN was a major component of their HICN. To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to be used by Medicare for limited administrative purposes after 2019 but starting in 2020 the MBI became the primary identifier for Medicare beneficiaries. HICN consists of two components: SSN and alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based).
Mandatory	A code indicating the patient's status as of the last day the claim covers. Values used are from UB-04. This is also referred to as patient discharge status. A valid list of codes can be purchased at: https://www.nubc.org/license
Mandatory	The Remittance Advice Number is a sequential number that identifies the current Remittance Advice (RA) produced for a provider. The number is incremented by one each time a new RA is generated. The RA is the detailed explanation of the reason for the payment amount.
Conditional	The total amount paid by the patient for services where they are required to use their personal funds to cover part of their care before Medicaid funds can be utilized.
Conditional	The number of days of intermediate care for individuals with an intellectual disability that were paid for in whole or in part by Medicaid. If value exceeds 99998 days, code as 99998. (e.g., code 100023 as 99998).
Conditional	The number of days, during the period covered by Medicaid, on which the patient did not reside in the long term care facility.

Conditional	The number of days of nursing care included in this claim that were paid for, in whole or in part, by Medicaid. Includes days during which nursing facility received partial payment for holding a bed during patient leave days. If value exceeds 99998 days, code as 99998.
Conditional	An indicator that denotes that claims in excess of a pre-determined number of claim lines (threshold determined by the individual state) will be split during processing.
Conditional	A code to indicate whether an individual received services or equipment across state borders. (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their coinsurance for the covered services on the claim. Do not include coinsurance payments made by a third party/s on behalf of the beneficiary.
Conditional	The date the beneficiary paid the coinsurance amount.
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on the claim. Do not include copayment payments made by a third party/s on behalf of the beneficiary..
Conditional	The date the beneficiary paid the copayment amount.
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on the claim. Do not include copayment payments made by a third party/s on behalf of the beneficiary.
Conditional	The date the beneficiary paid the deductible amount.

Mandatory	An indicator to identify a claim that the state refused pay in its entirety.
Situational	An indicator signifying that the copay was discounted or waived by the provider (e.g., physician or hospital). Do not use to indicate administrative-level, Medicaid State Agency or Medicaid MCO copayment waived decisions.
Conditional	A free-form text field to indicate the health home program that authorized payment for the service on the claim or to identify the health home SPA in which an individual is enrolled. The name entered should be the name that the state uses to uniquely identify the team. A "Health Home Entity" can be a designated provider (e.g., physician, clinic, behavioral health organization), a health team which links to a designated provider, or a health team (physicians, nurses, behavioral health professionals). Because an identification numbering schema has not been established, the entities' names are being used instead.
Situational	The amount of money paid by a third party on behalf of the beneficiary towards coinsurance.
Conditional	The date the third party paid the coinsurance amount
Situational	The amount of money paid by a third party on behalf of the beneficiary towards copayment.
Situational	The date the third party paid the copayment amount.
Conditional	The National Provider ID (NPI) of the health home provider.

Conditional	The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the MBI over the course of 2018 and 2019. Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.
Conditional	The National Provider ID (NPI) of the doctor responsible for admitting a patient to a hospital or other inpatient health facility.
Conditional	The Medicaid ID of the doctor responsible for admitting a patient to a hospital or other inpatient health facility.
Conditional	This code describes the area of specialty for the provider being reported.
Conditional	Taxonomic classification (code) for a given healthcare provider, as defined by the National Uniform Claim Committee.
Conditional	A code to describe the type of provider being reported.
Conditional	The amount paid by Medicare on this claim. For claims where Medicare payment is only available at the line level, report the sum of all the line level Medicare payment amounts at the header.

Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location and Contact Info (PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the PRV.004 or PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.
Conditional	The total copayment amount on a claim that the beneficiary is obligated to pay for covered services. This is the total Medicaid or contract negotiated beneficiary copayment liability for covered service on the claim. Do not subtract out any payments made toward the copayment.
Conditional	The total coinsurance amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for covered services on the claim. Do not subtract out any payments made toward the coinsurance.
Conditional	The total deductible amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability minus previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.
Conditional	The combined amounts the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment, coinsurance, and/or deductible for the covered services on the claim. Only report this data element when the claim does not differentiate among copayment, coinsurance, and/or deductible payments made by the beneficiary. Do not include beneficiary cost sharing payments made by a third party/ies on behalf of the beneficiary.
Mandatory	Billing provider address line 1 from X12 837I loop 2010AA.
Conditional	Billing provider address line 2 from X12 837I loop 2010AA.
Mandatory	Billing provider address city name from X12 837I loop 2010AA.
Mandatory	Billing provider address state code from X12 837I loop 2010AA.

Mandatory	Billing provider address ZIP code from X12 837I loop 2010AA.
Conditional	Service facility location organization NPI from X12 837I loop 2310E.
Conditional	Service facility location address line 1 from X12 837I loop 2310E.
Conditional	Service facility location address line 2 from X12 837I loop 2310E.
Conditional	Service facility location address city name from X12 837I loop 2310E.
Conditional	Service facility location address state code from X12 837I loop 2310E.
Conditional	Service facility location address ZIP code from X12 837I loop 2310E.
Mandatory	A code indicating the format in which the provider submitted their claim. Very few if any claims should be classified as "Other".
Conditional	A free-form text field where a state can identify the "other" claim form used by the provider to submit their claim. Required when "Other" is reported to Provider Claim Form Code.
Conditional	The amount included in the Total Medicaid Amount (CLT.002.065) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.

Conditional	The component (in dollar and cents) of the total allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Conditional	The component (in dollar and cents) of the total paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/

Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.
Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	A unique number to identify the transaction line number that is being reported on the original claim.
Conditional	A unique number to identify the transaction line number that identifies the line number on the adjustment claim.
Conditional	A code to indicate the type of adjustment record claim/encounter represents at claim detail level.
Conditional	Claim adjustment reason codes communicate why a service line was paid differently than it was billed.
Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.
Conditional	The claim line status codes from the 277 transaction set identify the status of a specific detail claim line rather than the entire claim. Only report the claim line for the final, adjudicated claim.

Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, this would be the date on which the service covered by this claim began.
Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended.
Mandatory	A code which identifies a specific accommodation, ancillary service or billing calculation (as defined by UB-04 Billing Manual). Revenue Code should be passed through to T-MSIS exactly as it was billed by the provider on the provider's 837I or UB-04 claim. It is only required on Inpatient, Long-Term Care and Other Fee for Service claims and managed care encounters that have a valid Type of Bill value. It's not required on financial transactions or non-institutional claims.
Mandatory	On facility claims/encounters, this field is to capture the actual service quantity by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood, etc. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed. For CLAIMOT claims/encounter records use Service Quantity Actual and CLAIMRX claims/encounter records use the Prescription Quantity Actual field

Conditional	On facility claims/encounters, this field is to capture maximum allowable quantity by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood, etc. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was allowed. This field is only applicable when the service being billed can be quantified in discrete units, e.g., a number of visits or the number of units of a prescription/refill that were filled. For CLAIMOT claims/encounters use Service Quantity Allowed and CLAIMRX claims/encounters use the Prescription Quantity Allowed field.
Conditional	The total amount billed for the related Revenue Code. Total amount billed includes both covered and non-covered charges (as defined by UB-04 Billing Manual). For encounter records, Type of Claim = 3, C, or W, this field should be populated with the amount that the provider billed to the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the provider billed the sub-capitated entity at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The maximum amount displayed at the claim line level as determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity allowed at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim detail level paid by the third party.

Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.
Conditional	The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity paid the provider at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The amount that would have been paid had the services been provided on a Fee for Service basis.
Conditional	Unit of billing that is used for billing services by the facility.
Mandatory	A code to categorize the services provided to a Medicaid or CHIP enrollee.
Conditional	A unique number to identify the provider who treated the recipient. The Servicing Provider Number should be for the individual doctor who rendered the service. If "Servicing" provider and the "Billing" provider such as a sole-practitioner are the same then use the same number in both fields. The value is conditional as its usage varies by state.
Conditional	The NPI of the health care professional who delivers or completes a particular medical service or non-surgical procedure. The Servicing Provider NPI Number is required when rendering provider is different than the attending provider and state or federal regulatory requirements call for a "combined claim" (i.e., a claim that includes both facility and professional components). Examples are Medicaid clinic bills or critical access hospital claims.
Conditional	A code to describe the type of provider being reported.

Conditional	This code describes the area of specialty for the provider being reported.
Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.
Conditional	A code to indicate the Federal funding source for the payment.
Mandatory	The type of facility in which services on the claim were rendered. The Provider Facility Type code set is based on corresponding groups of HIPAA provider taxonomy codes.
Conditional	A code following the National Drug Code format indicating the drug, device, or medical supply covered by this claim.
Conditional	A code to indicate the basis by which the quantity of the National Drug Code is expressed.
Conditional	This field is to capture the actual quantity of the National Drug Code being prescribed on the claim/encounters.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	This data element is not applicable to this file type.
Conditional	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved. (Also referred to as a Prior Authorization or Referral Number).
Mandatory	To indicate Services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.

Conditional	An unique identifier assigned to every medical device that meets the requirements of 21 CFR 801 and 830.
Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.
Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.
Conditional	The amount included in the Medicaid Amount (CLT.003.208) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.

Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number is not available, but the physician's Drug Enforcement Agency (DEA) ID is on the State file, then the State should use the DEA ID for this data element.
Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.
Conditional	The component (in dollar and cents) of the allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Conditional	The component (in dollar and cents) of the paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.

Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	Indicates the context of the diagnosis code from the provider's claim (i.e., an 837I claim can have one principal diagnosis code, one admitting diagnosis code, up to 12 external cause of injury diagnosis codes, and up to 24 other diagnosis codes; a UB-04 claim can have one principal diagnosis code, one admitting diagnosis code, and up to 17 other diagnosis codes). The type of diagnosis code (e.g., principal, admitting, external cause of injury, or other) is captured here. The order in which the diagnosis code was reported is captured in the Diagnosis Sequence Number.
Mandatory	The order in which the diagnosis occurred on the provider's claim for a given type of diagnosis code (e.g., an 837I claim can have up to 12 external cause of injury diagnosis codes and up to 24 other diagnosis codes).
Mandatory	Flag used to identify wither the associated Diagnosis Code value is a ICD-9 or ICD-10 code.
Mandatory	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as '2105'.

Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.
Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.
Mandatory	Denotes which supported file encoding standard was used to create the file.
Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file.
Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.

Mandatory	The date on which the file was created.
Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.
Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.
Mandatory	A code to indicate whether the records in the file are test or production records.
Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.
Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.
Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.
Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/

Mandatory	An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.
Conditional	In the claims files this data element indicates whether the claim or encounter was covered under the authority of an 1115A demonstration. In the Eligibility file, this data element indicates whether the individual participates in an 1115A demonstration.
Mandatory	Indicates the type of adjustment record.
Conditional	Claim adjustment reason codes communicate why a claim was paid differently than it was billed.
Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, this would be the date on which the service covered by this claim began.

Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3, C, W), the date the managed care organization paid the provider for the claim or adjustment.
Mandatory	A code to indicate what type of payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = '3' for a Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter record
Conditional	A data element corresponding with UB-04 form locator FL4 that classifies the claim as to the type of facility (2nd digit), type of care (3rd digit) and the billing record's sequence in the episode of care (4th digit). (Note that the 1st digit is always zero.)
Conditional	The health care claim status codes convey the status of an entire claim status codes from the 277 transaction set. Only report the claim status for the final, adjudicated claim.
Mandatory	The general category of the claim status (accepted, rejected, pended, finalized, additional information requested, etc.) from the 277 transaction set which is then further detailed in the companion data element claim status.

Mandatory	The field denotes the claims payment system from which the claim was extracted. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report a SOURCE-LOCATION = '22' to indicate that the sub-capitated entity paid a provider for the service to the enrollee on a FFS basis. For sub-capitated encounters from a sub-capitated network provider that were submitted to sub-capitated entity, report a SOURCE-LOCATION = '23' to indicate that the sub-capitated network provider provided the service directly to the enrollee. For sub-capitated encounters from a sub-capitated network provider, report a SOURCE-LOCATION = “23” to indicate that the sub-capitated network provider provided the service directly to the enrollee.
Conditional	The check or electronic funds transfer number.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.
Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).
Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).

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Conditional	The total amount billed for this claim at the claim header level as submitted by the provider. For encounter records, when Type of Claim value is in [3, C, W], then value must equal amount the provider billed to the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the provider billed the sub-capitated entity for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The claim header level maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On FFS claims the Allowed Amount is determined by the state's MMIS. On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity allowed for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.

Conditional	The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment at the claim header level, which is the sum of the amounts paid by Medicaid or the managed care plan at the detail level for the claim. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity paid the provider for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The amount paid by Medicaid/CHIP, on this claim at the claim header level, toward the beneficiary's Medicare deductible. If the Medicare deductible amount can be identified separately from Medicare coinsurance payments, code that amount in this field. If the Medicare coinsurance and deductible payments cannot be separated, fill this field with the combined payment amount, code Medicare Combined Indicator a '1' and leave Total Medicare Coinsurance Amount unpopulated.
Conditional	The total amount paid by the Medicaid/CHIP agency or a managed care plan towards the portion of the Medicare allowed charges that Medicare applied to coinsurance.
Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim header level paid by the third party.

Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.
Conditional	The field denotes whether the insured party is covered under an other insurance plan other than Medicare or Medicaid.
Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.
Conditional	This indicator indicates that the reimbursement amount included on the claim is for a fixed payment. Fixed payments are made by the state to insurers or providers for premiums or eligible coverage, not for a particular service. For example, some states have Primary Care Case Management programs where the state pays providers a monthly patient management fee of $3.50 for each eligible participant under their care. This fee is considered a fixed payment. It is very important for states to correctly identify fixed payments. Fixed payments do not have a defined 'medical record' associated with the payment; therefore, fixed payments are not subject to medical record request and medical record review.
Conditional	A code to indicate the source of non-federal share funds.
Conditional	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Conditional	Code indicating that the amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare deductible was combined with their coinsurance amount because the amounts could not be separated.

Mandatory	A code to indicate special Medicaid program under which the service was provided.
Conditional	A unique number assigned by the state which represents a distinct comprehensive managed care plan, prepaid health plan, primary care case management program, a program for all-inclusive care for the elderly entity, or other approved plans. For sub-capitated encounters from a sub-capitated entity or sub-capitated network provider, report the PLAN-ID-NUMBER for the MCP (MCO, PIHP, or PAHP that has a contract with a state) that is making the payment to the sub-capitated entity or sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.

Mandatory	The field denotes whether the payment amount was determined at the claim header or line/detail level. For claims where payment is NOT determined at the individual line level (PAYMENT-LEVEL-IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts are left blank and the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amount is reported at the header level only. For claims where payment/allowed amount is determined at the individual lines and when applicable, cost-sharing and/or coordination of benefits were deducted from one or more specific line-level payment/allowed amounts (PAYMENT-LEVEL-IND = 2), the allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the claim header. For claims where payment/allowed amount is determined at the individual lines but then cost sharing or coordination of benefits was deducted from the total paid/allowed amount at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-PAID-AMT) would be blank and line-level allowed (ALLOWED-AMT) and header level total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts must all be populated but the line level allowed amounts are not expected to sum exactly to the header level total allowed. For example, if a claim for an office visit and a procedure is assigned a separate line-level allowed amount for each line, but then at the header level a copay is deducted from the header-level total allowed and/or total paid amounts, then the sum of line-level allowed amounts may not be equal to the header-level total allowed amounts or correspond directly to the total paid amount. If the state cannot distinguish between the scenarios for value 1 and value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.
Conditional	A code to indicate the type of Medicare reimbursement.
Mandatory	The total number of lines on the claim.
Conditional	Indicates if the claim was processed by forcing it through a manual override process.

Conditional	This code indicates whether the claim has a Health Care Acquired Condition. For additional coding information refer to the following site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/hospitalacqcond/05_Coding.asp#TopOfPage
Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.
Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.
Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.
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Conditional	The start date of the corresponding occurrence code or occurrence span codes.
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Conditional	The start date of the corresponding occurrence code or occurrence span codes.
Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.
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Conditional	A patient's unique number assigned by the provider agency during claim submission, which identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment
Conditional	The last name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)
Conditional	The first name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)
Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).
Mandatory	An individual's date of birth.
Conditional	Indicates whether the claim is submitted by a provider or provider group enrolled in the Health Home care model to provide services for the beneficiary on the claim. Health home providers provide service for patients with chronic illnesses. States that do not specify an eligible individual's health home provider number, if applicable, should not report claims that indicate the claim is submitted by a provider or provider group enrolled in the health home model.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which claim is submitted.
Conditional	Field specifying the waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.

Conditional	A unique identification number assigned by the state to a provider or managed care plan. This data element should represent the entity billing for the service. For encounter records, if associated Type of Claim value equals 3, C, or W, then value must be the state identifier of the provider or entity (billing or reporting) to the managed care plan.
Conditional	The National Provider ID (NPI) of the billing entity responsible for billing a patient for healthcare services. The billing provider can also be servicing, referring, or prescribing provider. Can be admitting provider except for Long Term Care. For sub-capitation payments, report the national provider identifier (NPI) for the sub-capitated entity if the provider has one.
Conditional	The taxonomy code for the provider billing for the service.
Conditional	A code to describe the type of provider being reported.
Conditional	This code describes the area of specialty for the provider being reported.
Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number is not available, but the physician's Drug Enforcement Agency (DEA) ID is on the State file, then the State should use the DEA ID for this data element.
Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.

Conditional	The Medicare HIC Number (HICN) is an identifier formerly used by SSA and CMS to identify all Medicare beneficiaries. For many beneficiaries, their SSN was a major component of their HICN. To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to be used by Medicare for limited administrative purposes after 2019 but starting in 2020 the MBI became the primary identifier for Medicare beneficiaries. HICN consists of two components: SSN and alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based).
Conditional	A data element corresponding with line 24b on the CMS-1500 that indicates where the services took place. This is a pass-through data element that should not be modified or derived when missing unless otherwise specified.
Mandatory	The Remittance Advice Number is a sequential number that identifies the current Remittance Advice (RA) produced for a provider. The number is incremented by one each time a new RA is generated. The RA is the detailed explanation of the reason for the payment amount.
Conditional	The amount a policy will pay per day for a covered service. In some cases for OT claims this is referred to as a flat rate.
Conditional	A code to indicate whether an individual received services or equipment across state borders. (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their coinsurance for the covered services on the claim. Do not include coinsurance payments made by a third party/s on behalf of the beneficiary.
Conditional	The date the beneficiary paid the coinsurance amount.
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on the claim. Do not include copayment payments made by a third party/s on behalf of the beneficiary.
Conditional	The date the beneficiary paid the copayment amount.
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their deductible for the covered services on the claim. Do not include deductible payments made by a third party/s on behalf of the beneficiary.

Conditional	The date the beneficiary paid the deductible amount.
Mandatory	An indicator to identify a claim that the state refused pay in its entirety.
Situational	An indicator signifying that the copay was waived by the provider
Conditional	A free-form text field to indicate the health home program that authorized payment for the service on the claim or to identify the health home SPA in which an individual is enrolled. The name entered should be the name that the state uses to uniquely identify the team. A "Health Home Entity" can be a designated provider (e.g., physician, clinic, behavioral health organization), a health team which links to a designated provider, or a health team (physicians, nurses, behavioral health professionals). Because an identification numbering schema has not been established, the entities' names are being used instead.
Situational	The amount of money paid by a third party on behalf of the beneficiary towards coinsurance.
Conditional	The date the third party paid the coinsurance amount
Situational	The amount of money paid by a third party on behalf of the beneficiary towards copayment.
Situational	The date the third party paid the copayment amount.
Conditional	The National Provider ID (NPI) of the health home provider.

Conditional	The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the MBI over the course of 2018 and 2019. Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.
Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location and Contact Info (PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the PRV.004 or PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.
Conditional	The total copayment amount on a claim that the beneficiary is obligated to pay for covered services. This is the total Medicaid or contract negotiated beneficiary copayment liability for covered service on the claim. Do not subtract out any payments made toward the copayment.
Conditional	The total coinsurance amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for covered services on the claim. Do not subtract out any payments made toward the coinsurance.
Conditional	The total deductible amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability minus previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.

Conditional	The combined amounts the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment, coinsurance, and/or deductible for the covered services on the claim. Only report this data element when the claim does not differentiate among copayment, coinsurance, and/or deductible payments made by the beneficiary. Do not include beneficiary cost sharing payments made by a third party/ies on behalf of the beneficiary.
Conditional	The total amount paid by the patient for services where they are required to use their personal funds to cover part of their care before Medicaid funds can be utilized.
Mandatory	Billing provider address line 1 from X12 837I, 837P, and 837D loop 2010AA.
Conditional	Billing provider address line 2 from X12 837I, 837P, and 837D loop 2010AA.
Mandatory	Billing provider address city name from X12 837I, 837P, and 837D loop 2010AA.
Mandatory	Billing provider address state code from X12 837I, 837P, and 837D loop 2010AA.
Mandatory	Billing provider address ZIP code from X12 837I, 837P, and 837D loop 2010AA.
Conditional	Service facility location organization NPI from X12 837I loop 2310E or 837P and 837D loop 2310C.
Conditional	Service facility location address line 1 from X12 837I loop 2310E or 837P and 837D loop 2310C.

Conditional	Service facility location address line 2 from X12 837I loop 2310E or 837P and 837D loop 2310C.
Conditional	Service facility location address city name from X12 837I loop 2310E or 837P and 837D loop 2310C.
Conditional	Service facility location address state code from X12 837I loop 2310E or 837P and 837D loop 2310C.
Conditional	Service facility location address ZIP code from X12 837I loop 2310E or 837P and 837D loop 2310C.
Mandatory	A code indicating the format in which the provider submitted their claim. Very few if any claims should be classified as "Other".
Conditional	A free-form text field where a state can identify the "other" claim form used by the provider to submit their claim. Required when "Other" is reported to Provider Claim Form Code.
Conditional	The amount included in the Total Medicaid Amount (COT.002.050) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.
Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number is not available, but the physician's Drug Enforcement Agency (DEA) ID is on the State file, then the State should use the DEA ID for this data element. This is only applicable when a provider reports a second referral at the header of their claim.
Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient. This is only applicable when a provider reports a second referral at the header of their claim.

Conditional	The component (in dollar and cents) of the total allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Conditional	The component (in dollar and cents) of the total paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.

Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	A unique number to identify the transaction line number that is being reported on the original claim.
Conditional	A unique number to identify the transaction line number that identifies the line number on the adjustment claim.
Conditional	A code to indicate the type of adjustment record claim/encounter represents at claim detail level.
Conditional	Claim adjustment reason codes communicate why a service line was paid differently than it was billed.
Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.
Conditional	The claim line status codes from the 277 transaction set identify the status of a specific detail claim line rather than the entire claim. Only report the claim line for the final, adjudicated claim.

Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, this would be the date on which the service covered by this claim began.
Mandatory	For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended.
Conditional	A code which identifies a specific accommodation, ancillary service or billing calculation (as defined by UB-04 Billing Manual). Revenue Code should be passed through to T-MSIS exactly as it was billed by the provider on the provider's 837I or UB-04 claim. It is only required on Inpatient, Long-Term Care and Other Fee for Service claims and managed care encounters that have a valid Type of Bill value. It's not required on financial transactions or non-institutional claims.
Conditional	A field to capture the CPT or HCPCS code that describes a service or good rendered by the provider to an enrollee on the specified date of service.

Conditional	The date upon which a reported medical procedure was performed.
Conditional	A flag that identifies the coding system used for an associated procedure code.
Conditional	The procedure code modifier used with an associated procedure code. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.
Conditional	The amount billed at the claim detail level as submitted by the provider. For encounter records, Type of Claim = 3, C, or W, this field should be populated with the amount that the provider billed the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the provider billed the sub-capitated entity at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The maximum amount displayed at the claim line level as determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity allowed at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.

Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on a claim line. Do not include copayment payments made by a third party/ies on behalf of the beneficiary. This is a copayment paid for a service in the corresponding claim line for OT and RX claim files. The Beneficiary Copayment Paid Amount is an optional line level data element reported for OT and RX claim file types, only. If the beneficiary copayment paid amount is not available at the claim line level, report the total copayment paid amount in the header level copayment data element.
Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim detail level paid by the third party.
Conditional	The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity paid the provider at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The amount that would have been paid had the services been provided on a Fee for Service basis.
Conditional	The amount paid by Medicare on this claim. For claims where Medicare payment is only available at the header level, report the entire payment amount on the T-MSIS claim line with the highest charge or the 1st non-denied line. Zero fill Medicare Paid Amount on all other claim lines.
Mandatory	The quantity of a service or product that is rendered for a specific date of service or billing time span as reported by revenue code or procedure code on the claim/encounter line. For use with CLAIMOT claims. For CLAIMRX claims/encounters, use the Prescription Quantity Actual field. For CLAIMIP and CLAIMLT claims/encounters, use the Revenue Center Quantity Actual field.

Conditional	The maximum allowable quantity of a service that may be rendered per date of service or per month. For use with CLAIMOT claims/encounters. For CLAIMIP and CLAIMLT claims/encounters, use the Revenue Center Quantity Allowed field. NOTE: One prescription for 100 250 milligram tablets results in Service Quantity Allowed = 100. This field is only applicable when the service being billed can be quantified in discrete units, e.g., a number of visits or the number of units of a prescription/refill that were filled. For prescriptions/refills, use the Medicaid Drug Rebate definition of a unit, which is the smallest unit by which the drug is normally measured; e.g. tablet, capsule, milliliter, etc. For drugs not identifiable or dispensed by a normal unit, e.g. powder filled vials, use 1 as the number of units.
Mandatory	A code to categorize the services provided to a Medicaid or CHIP enrollee.
Conditional	A code to indicate that the service represents a long-term care home and community based service or support for an individual with chronic medical and/or mental conditions. The codes help to delineate between acute care and long-term care provided in the home and community setting (e.g. 1915(c), 1915(i), 1915(j), and 1915(k) services).

Conditional	A code to classify the home and community based services listed on the claim into the HCBS taxonomy. The HCBS Taxonomic classification system was adopted by CMS in August 2012. To acknowledge state variation, services and categories are defined based on the minimum definition necessary to establish mutually distinct categories and services. Some services are defined in part by characteristics that are NOT in that service. For example, the difference between companion services and personal care is that companion services do not include assistance with activities of daily living (ADLs) such as bathing, dressing, eating, and toileting. Some of the services reflected by the HCBS Taxonomy including, but not limited to personal care, case management, home health aide, and physician services, may (and in some case, must) also be covered under the Medicaid State Plan. The definitions below only define these services for purposes of Section 1915(c) Waivers and the State Plan Home and Community-Based Services benefit authorized by Section 1915(i). States interested in reflecting services as “extended state plan” services must offer them in accordance with state plan service definitions. Consult with the CMS Division of Benefits and Coverage in those instances to ensure definition alignment. The services and categories are arranged in order of consideration for placing a particular state service in the taxonomy. If one is not sure how to map a state’s service to the taxonomy, one should first consider Case Management, then Round-the-Clock Services, then Supported Employment, etc. Documentation of the HCBS Taxonomy from the CMS Waiver Management System can be found here: https://wms-mmdl.cms.gov/WMS/help/TaxonomyCategoryDefinitions.pdf.
Conditional	A unique number to identify the provider who treated the recipient. The Servicing Provider Number should be for the individual doctor who rendered the service. If "Servicing" provider and the "Billing" provider such as a sole-practitioner are the same then use the same number in both fields. The value is conditional as its usage varies by state.
Conditional	The NPI of the health care professional who delivers or completes a particular medical service or non-surgical procedure. The SERVICING-PROV-NPI-NUM is required when rendering provider is different than the attending provider and state or federal regulatory requirements call for a "combined claim" (i.e., a claim that includes both facility and professional components). Examples are Medicaid clinic bills or critical access hospital claims.
Conditional	The taxonomy code for the provider who treated the recipient.

Conditional	A code to describe the type of provider being reported.
Conditional	This code describes the area of specialty for the provider being reported.
Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.
Conditional	A code to identify the tooth numbering system being used.
Conditional	The tooth number serviced based on the tooth numbering system identified in the TOOTH-DESIGNATION-SYSTEM field.
Conditional	The area of the oral cavity is designated by a two-digit code.
Conditional	A code to identify the tooth's surface on which the service was performed.
Conditional	The street address of the origination point from which a patient is transported either from home or Long term care facility to a health care provider for healthcare services or vice versa. For transportation claims, this is only required if state has captured this information, otherwise it is conditional.

Conditional	The second line of the street address of the destination point to which a patient is transported either from home or Long term care facility to a health care provider for healthcare services or vice versa. For transportation claims, this is only required if state has captured this information, otherwise it is conditional.
Conditional	The name of the origination city from which a patient is transported either from home or a long term care facility to a health care provider for healthcare services or vice versa. For transportation claims, this is only required if state has captured this information, otherwise it is conditional.
Conditional	The ANSI numeric code of the origination state in which a patient is transported either from home or a long term care facility to a health care provider to a health care provider for healthcare services or vice versa.
Conditional	The zip code of the origination city from which a patient is transported either from home or long term care facility to a health care provider for healthcare services or vice versa.
Conditional	The street address of the destination point to which a patient is transported either from home or Long term care facility to a health care provider for healthcare services or vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.
Conditional	The street address of the destination point to which a patient is transported either from home or Long term care facility to a health care provider for healthcare services or vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.
Conditional	The name of the destination city to which a patient is transported either from home or a long term care facility to a health care provider for healthcare services or vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.
Conditional	The ANSI state numeric code for the U.S. state, Territory, or the District of Columbia code of the destination state in which a patient is transported either from home or a long term care facility to a health care provider for healthcare services or vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.
Conditional	The zip code of the destination city to which a patient is transported either from home or long term care facility to a health care provider for healthcare services or vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.

Conditional	A code to indicate the Federal funding source for the payment.
Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.
Conditional	A code following the National Drug Code format indicating the drug, device, or medical supply covered by this claim.
Conditional	The procedure code modifier used with an associated procedure code. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.
Conditional	The procedure code modifier used with an associated procedure code. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.
Conditional	The procedure code modifier used with an associated procedure code. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	A data element to identify how the beneficiary self-directed the service, i.e. hiring authority (the beneficiary has decision-making authority to recruit, hire, train and supervise the individuals who furnish his/her services), budget authority (The beneficiary has decision-making authority over how the Medicaid funds in a budget are spent), or both hiring and budget authority.
Conditional	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved. (Also referred to as a Prior Authorization or Referral Number).

Conditional	A code to indicate the basis by which the quantity of the National Drug Code is expressed.
Conditional	This field is to capture the actual quantity of the National Drug Code being prescribed on the claim/encounters.
Mandatory	To indicate Services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.
Mandatory	A pointer to the diagnosis code in the order of importance to this service.
Conditional	A pointer to the diagnosis code in the order of importance to this service.
Conditional	A pointer to the diagnosis code in the order of importance to this service.
Conditional	A pointer to the diagnosis code in the order of importance to this service.
Conditional	An unique identifier assigned to every medical device that meets the requirements of 21 CFR 801 and 830.
Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.

Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.
Conditional	Service facility location organization NPI from X12 837P loop 2420C and 837D loop 2420D.
Conditional	Service facility location address line 1 from X12 837P loop 2420C and 837D loop 2420D.
Conditional	Service facility location address line 2 from X12 837P loop 2420C and 837D loop 2420D.
Conditional	Service facility location address city name from X12 837P loop 2420C and 837D loop 2420D.

Conditional	Service facility location address state code from X12 837P loop 2420C and 837D loop 2420D.
Conditional	Service facility location address ZIP code from X12 837P loop 2420C and 837D loop 2420D.
Conditional	PLACE-OF-SERVICE is a pass-through data element meaning that the state should report the field in T-MSIS as reported by the provider on the claims form (i.e., 837P, CMS-1500, or 837D). If the claim is submitted on the 837p electronic claims form and the Facility Code Qualifier is reported with any value other than “B”, then the PLACE-OF-SERVICE value should be blank or space-filled. If the claim is submitted on the CMS 1450 (UB04) institutional claims form, the PLACE-OF-SERVICE field should be blank or space-filled. Otherwise, if the claim is submitted with the place of service populated with any value other than the valid values listed in T-MSIS Data Guide for PLACE-OF-SERVICE values, that value should still be reported in the PLACE-OF-SERVICE data element. If the claim is submitted by a provider with the place of service fields blank, then the PLACE-OF-SERVICE on the T-MSIS OT claims file should be blank or space-filled.
Conditional	The amount included in the Medicaid Amount (COT.003.178) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.
Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number is not available, but the physician's Drug Enforcement Agency (DEA) ID is on the State file, then the State should use the DEA ID for this data element. This is only applicable when a provider reports a second referral at the header of their claim.
Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.
Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number is not available, but the physician's Drug Enforcement Agency (DEA) ID is on the State file, then the State should use the DEA ID for this data element. This is only applicable when a provider reports a second referral at the header of their claim.

Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient. This is only applicable when a provider reports a second referral at the line/detail of their claim.
Conditional	The Medicaid provider ID of the Ordering Provider is the individual who requested the services or items being reported on this service line. Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.
Conditional	The Medicaid provider ID of the Ordering Provider is the individual who requested the services or items being reported on this service line. Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.
Conditional	The component (in dollar and cents) of the allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Conditional	The component (in dollar and cents) of the paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.

Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.
Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	Indicates the context of the diagnosis code from the provider's claim (i.e., an 837I claim can have one principal diagnosis code, up to 12 external cause of injury diagnosis codes, and up to 24 other diagnosis codes; a UB-04 claim can have one principal diagnosis code, one admitting diagnosis code, and up to 17 other diagnosis codes; an 837P or CMS-1500 claim can have up to 12 diagnosis codes; an 837D or ADA claim can have up to 4 diagnosis codes). The type of diagnosis code (e.g., principal, external cause of injury, or other) is captured here. The order in which the diagnosis code was reported is captured in the Diagnosis Sequence Number.
Mandatory	The order in which the diagnosis occurred on the provider's claim for a given type of diagnosis code (e.g., an 837P claim can have up to 12 external cause of injury diagnosis codes and up to 24 other diagnosis codes).
Mandatory	Flag used to identify wither the associated Diagnosis Code value is a ICD-9 or ICD-10 code.

Mandatory	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as '2105'.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.
Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.
Mandatory	Denotes which supported file encoding standard was used to create the file.
Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file.
Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	The date on which the file was created.

Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.
Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.
Mandatory	A code to indicate whether the records in the file are test or production records.
Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.
Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.
Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).

Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.
Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.

Conditional	In the claims files this data element indicates whether the claim or encounter was covered under the authority of an 1115A demonstration. In the Eligibility file, this data element indicates whether the individual participates in an 1115A demonstration.
Mandatory	Indicates the type of adjustment record.
Conditional	Claim adjustment reason codes communicate why a claim was paid differently than it was billed.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3, C, W), the date the managed care organization paid the provider for the claim or adjustment.
Mandatory	A code to indicate what type of payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = '3' for a Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter record.
Conditional	The health care claim status codes convey the status of an entire claim status codes from the 277 transaction set. Only report the claim status for the final, adjudicated claim.
Mandatory	The general category of the claim status (accepted, rejected, pended, finalized, additional information requested, etc.) from the 277 transaction set which is then further detailed in the companion data element claim status.

Mandatory	The field denotes the claims payment system from which the claim was extracted. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report a SOURCE-LOCATION = '22' to indicate that the sub-capitated entity paid a provider for the service to the enrollee on a FFS basis. For sub-capitated encounters from a sub-capitated network provider that were submitted to sub-capitated entity, report a SOURCE-LOCATION = '23' to indicate that the sub-capitated network provider provided the service directly to the enrollee. For sub-capitated encounters from a sub-capitated network provider, report a SOURCE-LOCATION = “23” to indicate that the sub-capitated network provider provided the service directly to the enrollee.
Conditional	The check or electronic funds transfer number.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.
Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).
Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).

Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).
Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).
Conditional	The total amount billed for this claim at the claim header level as submitted by the provider. For encounter records, when Type of Claim value is in [3, C, W], then value must equal amount the provider billed to the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the provider billed the sub-capitated entity for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The claim header level maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On FFS claims the Allowed Amount is determined by the state's MMIS. On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity allowed for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.

Conditional	The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment at the claim header level, which is the sum of the amounts paid by Medicaid or the managed care plan at the detail level for the claim. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity paid the provider for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The amount paid by Medicaid/CHIP, on this claim at the claim header level, toward the beneficiary's Medicare deductible. If the Medicare deductible amount can be identified separately from Medicare coinsurance payments, code that amount in this field. If the Medicare coinsurance and deductible payments cannot be separated, fill this field with the combined payment amount, code Medicare Combined Indicator a '1' and leave Total Medicare Coinsurance Amount unpopulated.
Conditional	The total amount paid by the Medicaid/CHIP agency or a managed care plan towards the portion of the Medicare allowed charges that Medicare applied to coinsurance.
Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim header level paid by the third party.

Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.
Conditional	The field denotes whether the insured party is covered under an other insurance plan other than Medicare or Medicaid.
Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.
Conditional	This indicator indicates that the reimbursement amount included on the claim is for a fixed payment. Fixed payments are made by the state to insurers or providers for premiums or eligible coverage, not for a particular service. For example, some states have Primary Care Case Management programs where the state pays providers a monthly patient management fee of $3.50 for each eligible participant under their care. This fee is considered a fixed payment. It is very important for states to correctly identify fixed payments. Fixed payments do not have a defined 'medical record' associated with the payment; therefore, fixed payments are not subject to medical record request and medical record review.
Conditional	A code to indicate the source of non-federal share funds.
Conditional	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Mandatory	A code to indicate special Medicaid program under which the service was provided.

Conditional	A unique number assigned by the state which represents a distinct comprehensive managed care plan, prepaid health plan, primary care case management program, a program for all-inclusive care for the elderly entity, or other approved plans.
Mandatory	The field denotes whether the payment amount was determined at the claim header or line/detail level. For claims where payment is NOT determined at the individual line level (PAYMENT-LEVEL-IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts are left blank and the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amount is reported at the header level only. For claims where payment/allowed amount is determined at the individual lines and when applicable, cost-sharing and/or coordination of benefits were deducted from one or more specific line-level payment/allowed amounts (PAYMENT-LEVEL-IND = 2), the allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the claim header. For claims where payment/allowed amount is determined at the individual lines but then cost sharing or coordination of benefits was deducted from the total paid/allowed amount at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-PAID-AMT) would be blank and line-level allowed (ALLOWED-AMT) and header level total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts must all be populated but the line level allowed amounts are not expected to sum exactly to the header level total allowed. For example, if a claim for an office visit and a procedure is assigned a separate line-level allowed amount for each line, but then at the header level a copay is deducted from the header-level total allowed and/or total paid amounts, then the sum of line-level allowed amounts may not be equal to the header-level total allowed amounts or correspond directly to the total paid amount. If the state cannot distinguish between the scenarios for value 1 and value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.

Conditional	A code to indicate the type of Medicare reimbursement.
Mandatory	The total number of lines on the claim.
Conditional	Indicates if the claim was processed by forcing it through a manual override process.
Conditional	A patient's unique number assigned by the provider agency during claim submission, which identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment
Conditional	The last name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)
Conditional	The first name of the individual to whom the services were provided.(The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)
Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).
Mandatory	An individual's date of birth.
Conditional	Indicates whether the claim is submitted by a provider or provider group enrolled in the Health Home care model to provide services for the beneficiary on the claim. Health home providers provide service for patients with chronic illnesses. States that do not specify an eligible individual's health home provider number, if applicable, should not report claims that indicate the claim is submitted by a provider or provider group enrolled in the health home model.

Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which claim is submitted.
Conditional	Field specifying the waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.
Conditional	A unique identification number assigned by the state to a provider or managed care plan. This data element should represent the entity billing for the service. For encounter records, if associated Type of Claim value equals 3, C, or W, then value must be the state identifier of the provider or entity (billing or reporting) to the managed care plan.
Conditional	The National Provider ID (NPI) of the billing provider responsible for billing for the service on the claim. The billing provider can also be servicing, referring, or prescribing provider; can be admitting provider except for Long Term Care.
Conditional	The taxonomy code for the provider billing for the service.

Conditional	This code describes the area of specialty for the provider being reported.
Mandatory	A unique identification number assigned by the state to the provider who prescribed the drug, device, or supply. This must be the individual's ID number, not a group identification number. If the prescribing physician provider ID is not available, but the physician's Drug Enforcement Agency (DEA) ID is on the state file, then the State should use the DEA ID for this data element
Mandatory	The National Provider ID (NPI) of the provider who prescribed a medication to a patient.
Conditional	The Medicare HIC Number (HICN) is an identifier formerly used by SSA and CMS to identify all Medicare beneficiaries. For many beneficiaries, their SSN was a major component of their HICN. To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to be used by Medicare for limited administrative purposes after 2019 but starting in 2020 the MBI became the primary identifier for Medicare beneficiaries. HICN consists of two components: SSN and alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based).
Mandatory	The Remittance Advice Number is a sequential number that identifies the current Remittance Advice (RA) produced for a provider. The number is incremented by one each time a new RA is generated. The RA is the detailed explanation of the reason for the payment amount.
Conditional	A code to indicate whether an individual received services or equipment across state borders. (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)
Mandatory	The date the drug, device, or supply was prescribed by the physician or other practitioner. This should not be confused with the Prescription Fill Date, which represents the date the prescription was actually filled by the provider.

Mandatory	Date the drug, device, or supply was dispensed by the provider.
Conditional	Indicator to specify if the drug is compound or not.
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their coinsurance for the covered services on the claim. Do not include coinsurance payments made by a third party/s on behalf of the beneficiary.
Conditional	The date the beneficiary paid the coinsurance amount.
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on the claim. Do not include copayment payments made by a third party/s on behalf of the beneficiary.
Conditional	The date the beneficiary paid the copayment amount.
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their deductible for the covered services on the claim. Do not include deductible payments made by a third party/s on behalf of the beneficiary.
Conditional	The date the beneficiary paid the deductible amount.
Mandatory	An indicator to identify a claim that the state refused pay in its entirety.

Situational	An indicator signifying that the copay was discounted or waived by the provider (e.g., physician or hospital). Do not use to indicate administrative-level, Medicaid State Agency or Medicaid MCO copayment waived decisions.
Conditional	A free-form text field to indicate the health home program that authorized payment for the service on the claim or to identify the health home SPA in which an individual is enrolled. The name entered should be the name that the state uses to uniquely identify the team. A "Health Home Entity" can be a designated provider (e.g., physician, clinic, behavioral health organization), a health team which links to a designated provider, or a health team (physicians, nurses, behavioral health professionals). Because an identification numbering schema has not been established, the entities' names are being used instead.
Situational	The amount of money paid by a third party on behalf of the beneficiary towards coinsurance.
Conditional	The date the third party paid the coinsurance amount
Situational	The amount of money paid by a third party on behalf of the beneficiary towards copayment.
Situational	The date the third party paid the copayment amount.
Mandatory	The National Provider ID (NPI) of the provider responsible for dispensing the prescription drug.
Conditional	The National Provider ID (NPI) of the health home provider.

Conditional	The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the MBI over the course of 2018 and 2019. Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.
Mandatory	The state-specific provider id of the provider who actually dispensed the prescription medication.
Conditional	Code indicating that the amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare deductible was combined with their coinsurance amount because the amounts could not be separated.
Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location and Contact Info (PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the PRV.004 or PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.
Conditional	How the prescription was sent to the pharmacy.

Conditional	The total copayment amount on a claim that the beneficiary is obligated to pay for covered services. This is the total Medicaid or contract negotiated beneficiary copayment liability for covered service on the claim. Do not subtract out any payments made toward the copayment.
Conditional	The total coinsurance amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for covered services on the claim. Do not subtract out any payments made toward the coinsurance.
Conditional	The total deductible amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability minus previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.
Conditional	The combined amounts the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment, coinsurance, and/or deductible for the covered services on the claim. Only report this data element when the claim does not differentiate among copayment, coinsurance, and/or deductible payments made by the beneficiary. Do not include beneficiary cost sharing payments made by a third party/ies on behalf of the beneficiary.
Conditional	The total amount paid by the patient for services where they are required to use their personal funds to cover part of their care before Medicaid funds can be utilized.
Mandatory	A code indicating the format in which the provider submitted their claim. Very few if any claims should be classified as "Other".
Conditional	A free-form text field where a state can identify the "other" claim form used by the provider to submit their claim. Required when "Other" is reported to Provider Claim Form Code.
Conditional	The amount included in the Total Medicaid Amount (CRX.002.041) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.
Conditional	The component (in dollar and cents) of the total allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).

Conditional	The component (in dollar and cents) of the total paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.

Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	A unique number to identify the transaction line number that is being reported on the original claim.
Conditional	A unique number to identify the transaction line number that identifies the line number on the adjustment claim.
Conditional	A code to indicate the type of adjustment record claim/encounter represents at claim detail level.
Conditional	Claim adjustment reason codes communicate why a service line was paid differently than it was billed.
Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.
Conditional	The claim line status codes from the 277 transaction set identify the status of a specific detail claim line rather than the entire claim. Only report the claim line for the final, adjudicated claim.
Mandatory	A code following the National Drug Code format indicating the drug, device, or medical supply covered by this claim.

Conditional	The amount billed at the claim detail level as submitted by the provider. For encounter records, Type of Claim = 3, C, or W, this field should be populated with the amount that the provider billed the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the provider billed the sub-capitated entity at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The maximum amount displayed at the claim line level as determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity allowed at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on a claim line. Do not include copayment payments made by a third party/ies on behalf of the beneficiary. This is a copayment paid for a service in the corresponding claim line for OT and RX claim files. The Beneficiary Copayment Paid Amount is an optional line level data element reported for OT and RX claim file types, only. If the beneficiary copayment paid amount is not available at the claim line level, report the total copayment paid amount in the header level copayment data element.
Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim detail level paid by the third party.

Conditional	The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity paid the provider at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.
Conditional	The amount that would have been paid had the services been provided on a Fee for Service basis.
Conditional	The amount paid by Medicaid/CHIP on this claim at the claim line level toward the beneficiary's Medicare deductible. If the Medicare deductible amount can be identified separately from Medicare coinsurance payments, code that amount in this field. If the Medicare coinsurance and deductible payments cannot be separated, fill this field with the combined payment amount and Medicare Coinsurance Payment is not required.
Conditional	The amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare coinsurance at the claim detail level. If the Medicare coinsurance amount can be identified separately from Medicare deductible payments, code that amount in this field. If Medicare coinsurance and deductible payments cannot be separated, populate the Medicare Deductible Amount.
Conditional	The amount paid by Medicare on this claim. For claims where Medicare payment is only available at the header level, report the entire payment amount on the T-MSIS claim line with the highest charge or the 1st non-denied line. Zero fill Medicare Paid Amount on all other claim lines.

Conditional	The maximum allowable quantity of a drug or service that may be dispensed per prescription per date of service or per month. Quantity limits are applied to medications when the majority of appropriate clinical utilizations will be addressed within the quantity allowed. For use with CLAIMRX claims/encounters. For CLAIMOT claims/encounters, use the Service Quantity Allowed field. For CLAIMIP and CLAIMLT claims/encounters, use the Revenue Center Quantity Actual field. One prescription for 100 250 milligram tablets results in Prescription Quantity Allowed =100.
Mandatory	The quantity of a drug that is dispensed for a prescription as reported by National Drug Code on the claim line. For use with CLAIMRX claims/encounters. For CLAIMOT claims/encounters, use the Service Quantity Actual field. For CLAIMIP and CLAIMLT claims/encounter records, use the Revenue Center Quantity Actual field.
Mandatory	A code to indicate the basis by which the quantity of the drug or supply is expressed.
Mandatory	A code to categorize the services provided to a Medicaid or CHIP enrollee.
Conditional	A code to indicate that the service represents a long-term care home and community based service or support for an individual with chronic medical and/or mental conditions. The codes help to delineate between acute care and long-term care provided in the home and community setting (e.g. 1915(c), 1915(i), 1915(j), and 1915(k) services).

Conditional	A code to classify the home and community based services listed on the claim into the HCBS taxonomy. The HCBS Taxonomic classification system was adopted by CMS in August 2012. To acknowledge state variation, services and categories are defined based on the minimum definition necessary to establish mutually distinct categories and services. Some services are defined in part by characteristics that are NOT in that service. For example, the difference between companion services and personal care is that companion services do not include assistance with activities of daily living (ADLs) such as bathing, dressing, eating, and toileting. Some of the services reflected by the HCBS Taxonomy including, but not limited to personal care, case management, home health aide, and physician services, may (and in some case, must) also be covered under the Medicaid State Plan. The definitions below only define these services for purposes of Section 1915(c) Waivers and the State Plan Home and Community-Based Services benefit authorized by Section 1915(i). States interested in reflecting services as "extended state plan" services must offer them in accordance with state plan service definitions. Consult with the CMS Division of Benefits and Coverage in those instances to ensure definition alignment. The services and categories are arranged in order of consideration for placing a particular state service in the taxonomy. If one is not sure how to map a state's service to the taxonomy, one should first consider Case Management, then Round-the-Clock Services, then Supported Employment, etc. Documentation of the HCBS Taxonomy from the CMS Waiver Management System can be found here: https://wms-mmdl.cms.gov/WMS/help/TaxonomyCategoryDefinitions.pdf.
Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.
Mandatory	Number of days supply dispensed.
Mandatory	Indicator showing whether the prescription being filled was a new prescription or a refill. If it is a refill, the indicator will indicate the number of refills.
Mandatory	Indicates whether the drug is a brand name, generic, single-source, or multi-source drug.

Mandatory	The charge to cover the cost of the professional dispensing fee for the prescription.
Mandatory	The unique identification number assigned by the pharmacy or supplier to the prescription.
Mandatory	A code indicating the conflict, intervention and outcome of a prescription presented for fulfillment. The T-MSIS Drug Utilization Code data element is composite field comprised of three distinct NCPDP data elements: 'Reason for Service Code' (439-E4); 'Professional Service Code' (440-E5); and 'Result of Service Code' (441-E6). All 3 of these NCPDP fields are situationally required and independent of one another. Pharmacists may report none, one, two or all three. NCPDP situational rules call for one or more of these values in situations where the field(s) could result in different coverage, pricing, patient financial responsibility, drug utilization review outcome, or if the information affects payment for, or documentation of, professional pharmacy service. The NCPDP 'Reasons of Service Code' (bytes 1 and 2 of the T-MSIS DRUG-UTILIZATION-CODE) explains whether the pharmacist filled the prescription, filled part of the prescription, etc. The NCPDP 'Professional Service Code' (bytes 3 and 4 of the T-MSIS Drug Utilization Code) describes what the pharmacist did for the patient. The NCPDP 'Result of Service Code' (bytes 5 and 6 of the T-MSIS Drug Utilization Code) describes the action the pharmacist took in response to a conflict or the result of a pharmacist's professional service. Because the T-MSIS Drug Utilization Code data element is a composite field, it is necessary for the state to populate all six bytes if any of the three NCPDP fields has a value. In such situations, use 'spaces' as placeholders for not applicable codes.
Conditional	Metric decimal quantity of the product with the appropriate unit of measure (each, gram, or milliliter).
Conditional	The physical form of a dose of medication, such as a capsule or injection.
Conditional	An indicator to identify claim lines with an NDC that is eligible for the drug rebate program.

Conditional	A code to indicate the Federal funding source for the payment.
Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	This data element is not applicable to this file type.
Conditional	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved. (Also referred to as a Prior Authorization or Referral Number).
Conditional	The charge to cover the cost of ingredients for the prescription or drug.
Conditional	The amount paid by Medicaid or the managed care plan on this claim or adjustment at the claim detail level towards the cost of ingredients for the prescription or drug.
Conditional	The amount paid by Medicaid or the managed care plan on this claim or adjustment towards the cost of the pharmacy's professional dispensing fee for the prescription.

Conditional	The charge to cover the clinical services, not otherwise covered under the professional dispensing fee. (Example - not filling a prescription because of therapeutic duplication).
Conditional	The amount paid by Medicaid or the managed care plan on this claim or adjustment towards the costs of clinical services not otherwise covered under the professional dispensing fee.
Mandatory	To indicate Services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.
Conditional	An unique identifier assigned to every medical device that meets the requirements of 21 CFR 801 and 830.
Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.

Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.
Conditional	The procedure code (e.g., CPT, HCPCS, or other procedure code that is not an NDC or UDI) reported by a pharmacy on their NCPDP transaction.
Conditional	The first modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).
Conditional	The second modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).
Conditional	The third modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).
Conditional	The fourth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).
Conditional	The fifth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).

Conditional	The sixth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).
Conditional	The seventh modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).
Conditional	The eighth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).
Conditional	The ninth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).
Conditional	The tenth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).
Conditional	The amount included in the Medicaid Amount (CRX.003.125) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.
Conditional	The component (in dollar and cents) of the allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Conditional	The component (in dollar and cents) of the paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).

Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.
Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.
Mandatory	Indicates the context of the diagnosis code from the provider's claim (i.e., an NCPDP claim can have up to 5 diagnosis codes). The type of diagnosis code (e.g., principal, admitting, external cause of injury, or other) is captured here. The order in which the diagnosis code was reported is captured in the Diagnosis Sequence Number.
Mandatory	The order in which the diagnosis occurred on the provider's claim for a given type of diagnosis code (e.g., an NCPDP claim can have up to 5 diagnosis codes).
Mandatory	Flag used to identify wither the associated Diagnosis Code value is a ICD-9 or ICD-10 code.

Mandatory	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as '2105'.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.
Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.
Mandatory	Denotes which supported file encoding standard was used to create the file.
Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file.
Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	The date on which the file was created.

Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.
Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.
Mandatory	A code to indicate whether the records in the file are test or production records.
Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.
Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.
Mandatory	The file submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit the file. This should correspond with the state's declared file submission method for the same file type and time period.
Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).

Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	Individual's first name; first name component of full name (e.g. First Name, Middle Initial, Last Name).
Mandatory	Individual's last name; last name component of full name (e.g. First Name, Middle Initial, Last Name).
Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).
Mandatory	Either individual's biological sex or their self-identified sex.

Mandatory	An individual's date of birth.
Conditional	The date an individual died on.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.

Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/

Conditional	A code to classify eligible individual's marital/domestic-relationship status. This element should be reported by the state when the information is material to eligibility (i.e., institutionalization). Because there is no specific statutory or regulatory basis for defining marital status codes, they are being defined in a way that is as flexible for states and data users as possible. States can report at whatever level of granularity is available to them in their system and a data user can choose to use them as-is or roll the values up in broader categories depending on whichever approach best meets their needs. CMS periodically reviews the values reported to MARITAL-STATUS-OTHER-EXPLANATION to determine if states are appropriately using it only when there is no existing MARITAL-STATUS value that reflects the state's marital status description for an individual AND to determine whether it is necessary to add additional T-MSIS MARITAL-STATUS values to reflect commonly used state martial status descriptions for which there is no existing T-MSIS MARITAL-STATUS value.
Conditional	A free-text field to capture the description of the marital/domestic-relationship status when Marital Status =14 (Other) is selected.
Conditional	The eligible individual's social security number. For newborns when value is unknown it is not required. For SSN states, in instances where the social security number is not known and a temporary MSIS Identification Number is used, the MSIS Identification Number field should be populated with the temporary MSIS Identification Number and the SSN field should be space-filled, or blank. When the SSN becomes known, the MSIS Identification Number field should continue to be populated with the temporary MSIS Identification Number and the SSN field should be populated with the newly acquired SSN for at least one monthly submission of the Eligible File so that T-MSIS can associated the temporary MSIS Identification Number and the social security number.
Mandatory	A code describing whether the state has verified the social security number (SSN) with the Social Security Administration (SSA).

Conditional	A code indicating the federal poverty level range in which the family income falls. If the beneficiary's income was assessed using multiple methodologies (MAGI and Non-MAGI), report the income that applies to their primary eligibility group. A beneficiary's income is applicable unless it is not required by the eligibility group for which they were determined eligible. For example, the eligibility groups for children with adoption assistance, foster care, or guardianship care under title IV-E and optional eligibility for individuals needing treatment for breast or cervical cancer do not have a Medicaid income test. Additionally, for individuals receiving SSI, states with section 1634 agreements with the Social Security Administration (SSA) and states that use SSI financial methodologies for Medicaid determinations do not conduct separate Medicaid financial eligibility for this group.
Conditional	A flag indicating if a non-citizen is exempt from the 5-year bar on benefits because they are a veteran or an active member of the military, naval or air service.
Mandatory	Indicates if the individual is identified as a U.S. Citizen.
Conditional	Indicates the individual is enrolled in Medicaid pending citizenship verification.
Mandatory	The immigration status of the individual.
Conditional	Indicates the individual is enrolled in Medicaid pending immigration verification.

Conditional	The date the five-year bar for an individual ends. Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that certain immigrants who enter the United States on or after August 22, 1996 are not eligible to receive federally-funded benefits, including Medicaid and the State Children's Health Insurance Program (Separate CHIP), for five years from the date they enter the country with a status as a "qualified alien."
Conditional	A code indicating the level of spoken English proficiency by the individual.
Conditional	A code indicating the language that is the individuals' preferred spoken or written language.
Mandatory	Household Size used in the Medicaid or CHIP eligibility determination process.
Conditional	A flag indicating the individual is pregnant at the time of application based on self-attestation.
Conditional	The Medicare HIC Number (HICN) is an identifier formerly used by SSA and CMS to identify all Medicare beneficiaries. For many beneficiaries, their SSN was a major component of their HICN. To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to be used by Medicare for limited administrative purposes after 2019 but starting in 2020 the MBI became the primary identifier for Medicare beneficiaries. HICN consists of two components: SSN and alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based).

Conditional	The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the MBI over the course of 2018 and 2019. Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.
Mandatory	A code used to distinguish among Medicaid, Medicaid Expansion CHIP, and Separate CHIP populations.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.

Conditional	This data element provides the beneficiary's or their household's income as a percentage of the federal poverty level. Used to assign the beneficiary to the eligibility group that covered their Medicaid or CHIP benefits. If the beneficiary's income was assessed using multiple methodologies (MAGI and Non-MAGI), report the income that applies to their primary eligibility group. A beneficiary's income is applicable unless it is not required by the eligibility group for which they were determined eligible. For example, the eligibility groups for children with adoption assistance, foster care, or guardianship care under title IV-E and optional eligibility for individuals needing treatment for breast or cervical cancer do not have a Medicaid income test. Additionally, for individuals receiving SSI, states with section 1634 agreements with the Social Security Administration (SSA) and states that use SSI financial methodologies for Medicaid determinations do not conduct separate Medicaid financial eligibility for this group.
Conditional	The date that a beneficiary signed their Medicaid or CHIP application. If the beneficiary was deemed eligible via an administrative determination then a signature may not be applicable/available.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.

Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	The type of address and contact information for the eligible submitted in the record segment.
Mandatory	The first line of a potentially multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).
Conditional	The second line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).
Conditional	The third line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).
Mandatory	The city component of an address associated with a given entity (e.g. person, organization, agency, etc.).
Mandatory	The ANSI state numeric code for the U.S. state, Territory, or the District of Columbia code for where the individual eligible to receive healthcare services resides. (The state for the type of address indicated in Address Type.)
Mandatory	U.S. ZIP Code component of an address associated with a given entity (e.g. person, organization, agency, etc.)

Mandatory	Standard ANSI code used to identify a specific U.S. County.
Conditional	Phone number for a given entity (e.g. person, organization, agency).
Conditional	A free-form text field to describe the type of living arrangement used for the eligibility determination process.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.

Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	The state-assigned number which uniquely identifies the Medicaid case to which the enrollee belongs. The definition of a case varies. There are single-person cases (mostly aged and blind/disabled) and multi-person cases (mostly TANF) in which all members of the case have the same case number, but a unique identification number. A warning for longitudinal research efforts: a case numbers associated with an individual may change over time.
Mandatory	Indicates coverage for individuals entitled to Medicare (Part A and/or B benefits) and eligible for some category of Medicaid benefits.

Mandatory	A flag indicating the eligibility record is the primary eligibility in cases where there are multiple eligibility records submitted with overlapping or concurrent eligibility determinant effective and end dates. It is expected that an enrollees' eligibility group assignment (ELG087 - ELIGIBILITY-GROUP) will change over time as his/her situation changes. Whenever the eligibility group assignment changes (i.e., ELG087 has a different value), a separate ELIGIBILITY-DETERMINANTS record segment must be created. In such situations, there would be multiple ELIGIBILITY-DETERMINANTS record segments, each covering a different effective time span. In such situations, the value in ELG087 would be the primary eligibility group for the effective date span of its respective ELIGIBILITY-DETERMINANTS record segment, and the PRIMARY-ELIGIBILITY-GROUP-IND data element on each of these segments would be set to '1' (YES). Should a situation arise where a Medicaid/CHIP enrollee has been assigned both a primary and one or more secondary eligibility groups, there would be two or more ELIGIBILITY-DETERMINANTS record segments with overlapping effective time spans - one segment containing the primary eligibility group and the other(s) for the secondary eligibility group(s). To differentiate the primary eligibility group from the secondary group(s), only one segment should be assigned as the primary group using PRIMARY-ELIGIBILITY-GROUP-IND = 1; the others should be assigned PRIMARY-ELIGIBILITY-GROUP-IND = 0.
Conditional	The eligibility group applicable to the individual based on the eligibility determination process. The valid value list of eligibility groups aligns with those being used in the Medicaid and CHIP Program Data System (MACPro).
Mandatory	The level of care required to meet an individual's needs and to determine LTSS program eligibility.
Conditional	A flag indicating if the individual is enrolled in Social Security Disability Insurance (SSDI) administered via the Social Security Administration (SSA).

Conditional	A flag indicating if the individual receives Supplemental Security Income (SSI) administered via the Social Security Administration (SSA).
Conditional	Indicates the individual's State Supplemental Income Status.
Conditional	Indicates the individual's SSI Status.
Mandatory	The composite of eligibility mapping factors used to create the corresponding Maintenance Assistance Status (MAS) and Basis of Eligibility (BOE) values (before January 1, 2014) and Eligibility Group values (on or after January 1, 2014). This field should not include information that already appears elsewhere on the Eligible File record even if it is part of the MAS and BOE or Eligibility Group algorithm (e.g., age information computed from Date of Birth or County Code).
Conditional	A flag to identify children eligible through the conception to birth option, which is available only through a separate State CHIP Program.

Conditional	The reason for a complete loss/termination in an individual's eligibility for Medicaid and CHIP. The end date of the segment in which the value is reported must represent the date that the complete loss/termination of Medicaid and CHIP eligibility occurred. The reason for the termination represents the reason that the segment in which it was reported was closed. If for a single termination in eligibility for a single individual there are multiple distinct co-occurring values in the state's system explaining the reason for the termination, and if one of the multiple co-occurring values maps to T-MSIS ELIGIBILITY-CHANGE-REASON value '21'; (Other) '22'; (Unknown), then the state should not report the co-occurring value '21'; and/or '22'; to T-MSIS. If there are multiple co-occurring distinct values between '01'; and '19', then the state should choose whichever is first in the state's system. Of the values that could logically co-occur in the range of '01'; through '19', CMS does not currently have a preference for any one value over another. Do not populate if at the time someone loses Medicaid eligibility they become eligible for and enrolled in CHIP. Also do not populate if at the time someone loses CHIP eligibility they become eligible for and enrolled in Medicaid.
Mandatory	A flag that indicates the scope of Medicaid or CHIP benefits to which an individual is entitled to.

Conditional	A flag that indicates whether the individual received Federal Temporary Assistance for Needy Families (TANF) benefits.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Conditional	The date by which a person's Medicaid or CHIP eligibility must be redetermined, per 1915(i)(1)(I), 42 CFR 435.916, 435.926, any other applicable regulations, or waiver of these regulations. This is effectively the "expiration date" of the eligibility characteristics with which the date is being reported. Upon this date the state is required to perform a renewal or redetermination of the individual's eligibility.
Conditional	A code to identify the authority used to extend eligibility during the period of coverage. This code should correspond to the eligibility characteristics, including eligibility redetermination date, with which the code is being reported.
Conditional	A free-form text field where a state can identify the “other” authority used to extend eligibility; required when 995 is used.
Conditional	A code to identify the authority used to provide continuous eligibility during the period of coverage
Conditional	A free-form text field where a state can identify the "other" authority used to provide continuous eligibility.
Conditional	An indicator that identifies the income standard used by the state to assign the corresponding primary eligibility group.
Conditional	A free-form text field where a state can identify the "other" income standard used to assign the corresponding primary eligibility group. Required when "Other" is reported to Income Standard Code.
Conditional	Value must be populated with a state-specific reason for termination when the ELIGIBILITY-TERMINATION-REASON value is 'Other'.

Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	A free-form text field for the name of the health home program approved by CMS. This name needs to be consistent across files to be used for linking.
Mandatory	A field to identify the health home SPA in which an individual is enrolled. Because an identification numbering schema has not been established, the entities' names are being used instead.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.

Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The date on which the health home entity was approved by CMS to participate in the Health Home Program.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
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Mandatory	A free-form text field for the name of the health home program approved by CMS. This name needs to be consistent across files to be used for linking.
Mandatory	A field to identify the health home SPA in which an individual is enrolled. Because an identification numbering schema has not been established, the entities' names are being used instead.

Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The date on which the health home entity was approved by CMS to participate in the Health Home Program.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
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Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	The chronic condition used to determine the individual's eligibility for the health home provision.
Conditional	A free-text field to capture the description of the other chronic condition (or conditions) when value "H" (Other) appears in the Health Home Chronic Condition data element.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).

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Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.
Mandatory	A code describing the provider type classification for which the provider/beneficiary lock-in relationship exists.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Conditional	The type(s) of services that are locked-in.
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
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Mandatory	A code indicating if the individual lives with his/her family or is not a participant in the MFP program.
Mandatory	A code describing type of qualified institution at the time of transition to the community for an eligible MFP Demonstration participant.
Mandatory	A code indicating the type of qualified residence.
Conditional	A code describing why an individual's participation in Money Follows the Person demonstration ended.

Conditional	A code describing why the individual was reinstitutionalized after participation in the Money Follows the Person Demonstration.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
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Mandatory	This field specifies the State Plan Options in which the individual is enrolled. Use on occurrence for each State Plan Option enrollment.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
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Mandatory	Field specifying the waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.
Mandatory	Code for specifying waiver types under which the eligible individual is covered during the month.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.

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Mandatory	The level of care provided to the individual by the long term care facility.
Mandatory	A unique identification number assigned by the state to the long term care facility furnishing healthcare services to the individual.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.

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Mandatory	The managed care plan identification number under which the eligible individual is enrolled. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed-Care-Plan-ID in the Eligible File". https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareplantype-in-the-eligible-file-managed-care/ See T-MSIS Guidance Document, "CMS Guidance: Preliminary guidance for Primary Care Case Management Reporting". https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/cms-guidance-primary-care-case-management-reporting-updated/

Mandatory	A model of health care delivery organized to provide a defined set of services. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Non-Emergency Medical Transportation (NEMT) Prepaid Ambulatory Health Plans (PAHPs) in the T-MSIS Managed Care File" https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-nonemergency-medical-transportation-nemt-prepaid-ambulatory-health-plans-pahps-in-the-tmsis-managed-care-filemanaged-care/ See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Care Plan Type in the T-MSIS Managed Care File" https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareplantype-in-the-t-msis-managed-care-file-managed-care/
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
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Situational	A free text field for the submitting state to enter whatever information it chooses.
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Mandatory	A code indicating that the individual's ethnicity is Hispanic, Latino/a, or Spanish ethnicity of a Medicaid/CHIP enrolled individual. Ethnicity Code clarifications: If state has beneficiaries coded in their database as "Hispanic" or "Latino," then code them in T-MSIS as "Hispanic or Latino Unknown" (valid value "5"). DO NOT USE "Another Hispanic, Latino, or Spanish Origin," "Ethnicity Unknown" or "Ethnicity Unspecified." NOTE 1: The "Ethnicity Unspecified" category in T-MSIS (valid value "6") should be used with an individual who explicitly did not provide information or refused to answer a question.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Conditional	A freeform field to document the ethnicity of the beneficiary when the beneficiary identifies themselves as Another Hispanic, Latino, or Spanish origin (ethnicity code 4).
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
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Mandatory	A code indicating the individual's race either in accordance with requirements of Section 4302 of the Affordable Care Act classifications. Race Code clarifications: If state has beneficiaries coded in their database as "Asian" with no additional detail, then code them in T-MSIS as "Asian Unknown" (valid value "011"). DO NOT USE "Other Asian," "Unspecified" or "Unknown". If state has beneficiaries coded in their database as "Native Hawaiian or Other Pacific Islander" with no additional detail, then code them in T-MSIS as "Native Hawaiian and Other Pacific Islander Unknown" (valid value "016"). DO NOT USE "Native Hawaiian," "Other Pacific Islander," "Unspecified" or "Unknown". If state has beneficiaries coded in their database as "Other" with no additional detail or in a category that is not available in the code set provided, then code them in T-MSIS as "Other" (valid value "018"), but only use "Other" if the use of "Other Asian" or "Other Pacific Islander" are not appropriate. DO NOT USE "Unspecified" or "Unknown". The "Other" valid value was added to T-MSIS to better align T-MSIS with the single-streamlined application and to accommodate some atypical states, despite the requirements of Section 4302 of the ACA. NOTE 1: The "Other Asian" category in T-MSIS (valid value "010") should be used in situations in which an individual's specific Asian subgroup is not available in the code set provided (e.g., Malaysian, Burmese). NOTE 2: The "Unspecified" category in T-MSIS (valid value "017") should be used with an individual who explicitly did not provide information or refused to answer a question.
Conditional	A freeform field to document the race of the beneficiary when the beneficiary identifies themselves as Other Asian, Other Pacific Islander (race codes 010 or 015).

Conditional	'American Indian or Alaska Native' means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, pursuant to 42 CFR 136.12. This means the individual: a. Is a member of a Federally-recognized Indian tribe; b. Resides in an urban center and meets one or more of the following four criteria: i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; ii. Is an Eskimo or Aleut or other Alaska Native; iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or iv. Is determined to be an Indian under regulations promulgated by the 'Secretary of Health and Human Services; c. Is considered by the Secretary of the Interior to be an Indian for any purpose; or d. Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native. NOTE Applicants who complete Appendix B of the Marketplace/Medicaid application and respond affirmatively to the two questions shown below are considered to meet the definition of an American Indian/Alaskan Native. Are you a member of a federally recognized tribe? Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).

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Mandatory	A code to identify disability status in accordance with requirements of Section 4302 of the Affordable Care Act.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
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Conditional	Indicates that the individual participates in an 1115A demonstration. 1115A is a Center for Medicare and Medicaid Innovation (CMMI) demonstration.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
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Mandatory	The chronic condition for which the eligible person is receiving non-Health-Home home and community based care.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).

Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	Identify the type of enrollment that the eligible person has been enrolled into as either Medicaid/Medicaid Expansion CHIP or Separate CHIP.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	A code to identify the kind of eligible identifier that is captured in the Eligible Identifier data element.
Situational	This data element is reserved for future use.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.

Mandatory	A data element to capture the various identifiers assigned to Medicaid and CHIP beneficiary by various entities. The specific type of identifier is shown in the corresponding value in the Eligible Identifier Type data element. States should provide all Old MSIS Identification Number with Eligible Identifier Type = 2 to T-MSIS in case the state changes the MSIS Identification Number of a beneficiary. The state should submit updates to T-MSIS whenever an identifier is retired or issued. States should provide Old MSIS Identification Number with Reason for Change = 'MERGE' to T-MSIS if the state was reporting multiple MSIS Identification Numbers for a single beneficiary and merges them under a single MSIS Identification Number. States should provide Old MSIS Identification Number with Reason for Change = 'UNMERGE' to T-MSIS if the state unmerges a beneficiary from another beneficiary. For example, if a newborn child is originally reported with the mother's MSIS Identification Number and is then assigned a different MSIS Identification Number. States should provide Old MSIS Identification Number with Reason for Change = 'LSE' to T-MSIS if the state assigns a new MSIS Identification Number to any beneficiaries during large system enhancement in state MMIS. States should provide Old MSIS Identification Number with Reason for Change = 'TCAM' to T-MSIS if the Medicaid and Separate CHIP programs use different MSIS Identifier Number schemas and beneficiaries are transferred from CHIP to Medicaid or from Medicaid to CHIP and a new MSIS Identification Number is issued.
Conditional	A code to identify the reason for changing the MSIS Identification Number of a beneficiary and only required for Eligible Identifier Type = '2-Old MSIS Identification Number'. For example, If MSIS Identification Number of a beneficiary is being changed due to 'Merge with other MSIS ID' or 'Unmerge'.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements, so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).

Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's sex assigned at birth (e.g., according to an original birth certificate or similar document). T-MSIS does not define or maintain these questions or responses. They are defined and maintained via the CMS single streamlined application and state Medicaid and CHIP agencies. T-MSIS is intended to reflect those sources and may be updated periodically as necessary to align with national standards and common practices. For more information, see: https://www.medicaid.gov/sites/default/files/2023-11/cib11092023.pdf.
Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's sex assigned at birth (e.g., according to an original birth certificate or similar document), if their response is not reflected by the values available for Sex Assigned at Birth.

Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's gender identify-MSIS does not define or maintain these questions or responses. They are defined and maintained via the CMS single streamlined application and state Medicaid and CHIP agencies. T-MSIS is intended to reflect those sources and may be updated periodically as necessary to align with national standards and common practices. For more information, see https://www.medicaid.gov/sites/default/files/2023-11/cib11092023.pdf.
Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's gender identify if their response is not reflected by the values available for Gender Identity.
Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's sexual orientation-MSIS does not define or maintain these questions or responses. They are defined and maintained via the CMS single streamlined application and state Medicaid and CHIP agencies. T-MSIS is intended to reflect those sources and may be updated periodically as necessary to align with national standards and common practices. For more information, see https://www.medicaid.gov/sites/default/files/2023-11/cib11092023.pdf.
Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's sexual orientation if their response is not reflected by the values available for Sexual Orientation.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.
Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.
Mandatory	Denotes which supported file encoding standard was used to create the file.
Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file.
Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	The date on which the file was created.
Mandatory	newly acquired SSN for at least one monthly submission of the Eligible File so that T-MSIS can associated the temporary MSIS Identification Number and the social security number.
Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.

Mandatory	A code to indicate whether the records in the file are test or production records.
Mandatory	with the temporary MSIS Identification Number and the SSN field should be space-filled, or blank. When the SSN becomes known, the MSIS Identification Number field should continue to be populated with the temporary MSIS Identification Number and the SSN field should be populated with the
Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.
Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Conditional	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.

Conditional	A unique claim/transaction number assigned by the state’s payment system that identifies the adjustment claim/transaction for an original item control number.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date that the payment or recoupment was executed by the payer.
Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.
Conditional	The check or electronic funds transfer number.
Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. This will typically correspond to the X12 820 Premium Payer.
Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.

Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".
Conditional	This describes the type of managed care plan or care coordination model of the payer, when applicable. The valid value list is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.
Conditional	This is a description of what type of managed care plan or care coordination model the payer ID was reported with a PAYER-MCR-PLAN-OR-OTHER-TYPE of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically correspond to the X12 820 Premium Receiver.
Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.
Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".
Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.

Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically belong to the entity identified as the X12 820 Premium Receiver.
Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.
Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".
Conditional	Managed care plan contract ID
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	The date representing the beginning of the period covered by the capitation or sub-capitation payment or recoupment; for example, the first day of the calendar month of beneficiary enrollment in the managed care plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).
Mandatory	The date representing the end of the period covered by the capitation or sub-capitation payment or recoupment; for example, the last day of the calendar month of beneficiary enrollment in the managed care plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).

Mandatory	A code to indicate the Federal funding source for the payment.
Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.
Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.

Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.
Conditional	A code to indicate the source of non-federal share funds.
Conditional	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Mandatory	Indicates whether the financial transaction from an MC plan to a provider or other entity is a type of State Directed Payment.
Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.
Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally submitted; xxxx = an Situational entry for specific SPA types

Mandatory	Indicates whether the transaction represents a sub-capitation payment between a managed care plan and a sub-capitated entity or sub-capitated network provider or not. A sub-capitation payment could also be between a sub-capitated entity and another sub-capitated entity or sub-capitated network provider.
Conditional	Cross-reference to the applicable payment category in the managed care plan's contract with the state Medicaid/CHIP agency or their fiscal intermediary.
Conditional	This is the description of the rate cell from the rate setting process that applies to the capitation payment. For example, a rate cell may represent the monthly capitation rate paid for adults with chronic conditions who live in a rural area. If the rate paid for this capitation payment is based on the rate cell for adults with chronic conditions who live in a rural area, then the rate cell description could be "Adults with chronic conditions living in a rural area."
Conditional	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.
Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.
Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.

Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.
Conditional	A unique claim/transaction number assigned by the state’s payment system that identifies the adjustment claim/transaction for an original item control number.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date that the payment or recoupment was executed by the payer.
Mandatory	The dollar amount being paid to the payee.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.
Conditional	The check or electronic funds transfer number.
Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. This will typically correspond to the X12 820 Premium Payer.

Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.
Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically correspond to the X12 820 Premium Receiver.
Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.
Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically belong to the entity identified as the X12 820 Premium Receiver.

Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.
Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".
Mandatory	The state-assigned identification number of the Third Party Liability (TPL) Entity.
Conditional	The ID number issued by the Insurance carrier providing third party liability insurance coverage to beneficiaries. Typically the Plan ID/Plan Number is on the beneficiaries' insurance card.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique “key” value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Conditional	Member identification number as it appears on the card issued by the TPL insurance carrier.
Mandatory	The date representing the beginning of the period covered by the premium payment or recoupment; for example, the first day of the calendar month of beneficiary coverage in the insurance plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).
Mandatory	The date representing the end of the period covered by the premium payment or recoupment; for example, the last day of the calendar month of beneficiary coverage in the insurance plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).
Mandatory	A code to indicate the Federal funding source for the payment.
Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).

Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.
Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.
Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.

Mandatory	A code to indicate the source of non-federal share funds.
Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.
Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types
Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.
Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.
Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.
Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date that the payment or recoupment was executed by the payer.
Mandatory	The dollar amount being paid to the payee.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.
Conditional	The check or electronic funds transfer number.

Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. This will typically correspond to the X12 820 Premium Payer.
Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.
Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically correspond to the X12 820 Premium Receiver.
Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.
Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".

Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically belong to the entity identified as the X12 820 Premium Receiver.
Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.
Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".
Mandatory	The state-assigned identification number of the Third Party Liability (TPL) Entity.
Conditional	The ID number issued by the Insurance carrier providing third party liability insurance coverage to beneficiaries. Typically the Plan ID/Plan Number is on the beneficiaries' insurance card.
Conditional	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique “key” value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/ MSIS-IDENTIFICATION-NUM is conditional in the FTX00004 segment because some members of a private group policy may not be eligible for Medicaid or CHIP, though at least one member of the group policy must be eligible for Medicaid or CHIP. There should be one FTX00004 segment for each member of the group policy for which the premium assistance payment is being paid, regardless of whether the member of the group policy was eligible for and enrolled in Medicaid or CHIP.

Conditional	The SSN of the member of the group insurance policy. Each FTX00004 segment represents a different member of a given group insurance policy. Typically all members of the group insurance policy will have both an MSIS ID and an SSN. Under some circumstances, it’s possible that or more members of a group insurance policy do not have an MSIS ID, but do have an SSN, if they are included on the group insurance policy but not eligible for Medicaid or CHIP. It’s also possible that one or more members of a group insurance policy do not have an SSN. If a member of a group insurance policy does not have an SSN, leave this field blank.
Conditional	Member identification number as it appears on the card issued by the TPL insurance carrier.
Conditional	The group number of the TPL health insurance policy.
Conditional	This code identifies the relationship of the policy holder to the Medicaid/CHIP beneficiary.
Mandatory	The date representing the beginning of the period covered by the premium payment or recoupment; for example, the first day of the calendar month of beneficiary coverage in the insurance plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).
Mandatory	The date representing the end of the period covered by the premium payment or recoupment; for example, the last day of the calendar month of beneficiary coverage in the insurance plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).
Conditional	A code to indicate the Federal funding source for the payment.
Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.

Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.
Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.
Conditional	A code to indicate the source of non-federal share funds.

Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.
Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types
Conditional	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.
Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.
Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).

Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.
Conditional	A unique claim/transaction number assigned by the state’s payment system that identifies the adjustment claim/transaction for an original item control number.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date that the payment or recoupment was executed by the payer.
Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.
Conditional	The check or electronic funds transfer number.
Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. For beneficiary Cost Sharing Offset, the payer is always the state and the payee is always a beneficiary.

Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.
Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. For beneficiary Cost Sharing Offset, the beneficiary is always the payee.
Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.
Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".
Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.
Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".

Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.
Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.
Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".
Conditional	Managed care plan contract ID
Conditional	The ID number issued by the Insurance carrier providing third party liability insurance coverage to beneficiaries. Typically the Plan ID/Plan Number is on the beneficiaries' insurance card.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique “key” value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	The date representing the beginning of the period covered by the capitation payment or premium payment that the beneficiary is offsetting; for example, the first day of the calendar month of beneficiary enrollment in the managed care plan to which the off-setting amount is applied. If returning money to the beneficiary, this is the date representing the beginning of the period for which the beneficiary had previously made an offsetting payment that is now being returned to them.

Mandatory	The date representing the end of the period covered by the capitation payment or premium payment that the beneficiary is offsetting; for example, the last day of the calendar month of beneficiary enrollment in the managed care plan to which the off-setting amount is applied. If returning money to the beneficiary, this is the date representing the end of the period for which the beneficiary had previously made an offsetting payment that is now being returned to them.
Mandatory	A code to indicate the Federal funding source for the payment.
Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.
Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.

Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.
Mandatory	A code to indicate the source of non-federal share funds.
Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Conditional	This indicates the type of payment that the beneficiary cost-sharing is/was offsetting.
Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.
Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types

Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.
Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.
Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.
Conditional	A unique claim/transaction number assigned by the state’s payment system that identifies the adjustment claim/transaction for an original item control number.
Mandatory	Indicates the type of adjustment record.

Mandatory	The date that the payment or recoupment was executed by the payer.
Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.
Conditional	The check or electronic funds transfer number.
Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped.
Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.
Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.

Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.
Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".
Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.
Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.
Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.
Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".
Conditional	Managed care plan contract ID

Conditional	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique “key” value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	The date representing the beginning of the performance period that the value-based dollar amount is rewarding or penalizing.
Mandatory	The date representing the end of the performance period that the value-based dollar amount is rewarding or penalizing.
Mandatory	A code to indicate the Federal funding source for the payment.
Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.

Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.
Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.
Mandatory	A code to indicate the source of non-federal share funds.
Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Mandatory	Indicates whether the financial transaction from an MC plan to a provider or other entity is a type of State Directed Payment.

Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.
Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types
Conditional	This is the type of value-based payment model to which the financial transaction applies. These values come from the “Alternative Payment Model (APM) Framework Final White Paper”, produced by the Healthcare Learning and Action Network. https://hcp-lan.org/work products/apm-whitepaper.pdf
Conditional	Cross-reference to the applicable payment category in the managed care plan's contract with the state Medicaid/CHIP agency or their fiscal intermediary.
Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.
Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.
Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.
Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date that the payment or recoupment was executed by the payer.
Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.
Conditional	The check or electronic funds transfer number.

Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped.
Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.
Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.
Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.

Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".
Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.
Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.
Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.
Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".
Mandatory	Managed care plan contract ID
Mandatory	The date representing the start of the time period that the payment is expected to be used by the provider.
Mandatory	The date representing the end of the time period that the payment is expected to be used by the provider.
Mandatory	A qualifier that identifies what the payment period begin and end dates represent. For example, the payment period begin an end dates may correspond to a range of service dates from claims or encounters or they may represent a period of beneficiary eligibility or enrollment.
Conditional	This is a description of the type of financial transaction when the PAYMENT-PERIOD-TYPE is "Other".

Mandatory	A code to indicate the Federal funding source for the payment.
Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.
Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.
Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.

Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.
Mandatory	A code to indicate the source of non-federal share funds.
Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.
Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types
Conditional	Cross-reference to the applicable payment category in the managed care plan's contract with the state Medicaid/CHIP agency or their fiscal intermediary.
Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.
Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.
Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.

Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.
Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date that the payment or recoupment was executed by the payer.
Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.
Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.

Conditional	The check or electronic funds transfer number.
Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped.
Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.
Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.

Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.
Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".
Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.
Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.
Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.
Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".
Mandatory	The date representing the beginning of the cost-settlement period. For example, if the cost-settlement is for the first calendar quarter of the year, then the cost settlement begin date would be March 1 of that year.

Mandatory	The date representing the end of the cost-settlement period. For example, if the cost-settlement is for the first calendar quarter of the year, then the cost settlement end date would be March 31 of that year.
Mandatory	A code to indicate the Federal funding source for the payment.
Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.
Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.

Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.
Mandatory	A code to indicate the source of non-federal share funds.
Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.
Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types
Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.

Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.
Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.
Conditional	A unique claim/transaction number assigned by the state’s payment system that identifies the adjustment claim/transaction for an original item control number.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date that the payment or recoupment was executed by the payer.
Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.

Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.
Conditional	The check or electronic funds transfer number.
Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped.
Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.
Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.

Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.
Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".
Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.
Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.
Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.
Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".
Mandatory	The date representing the beginning of the FQHC wrap payment or recoupment period. For example, if the FQHC wrap payment is for the first calendar quarter of the year, then the FQHC wrap payment begin date would be March 1 of that year.

Mandatory	The date representing the end of the FQHC wrap payment period. For example, if the FQHC wrap payment is for the first calendar quarter of the year, then the FQHC wrap payment end date would be March 31 of that year.
Mandatory	A code to indicate the Federal funding source for the payment.
Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).
Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.
Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.

Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.
Mandatory	A code to indicate the source of non-federal share funds.
Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.
Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types
Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.

Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.
Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.
Conditional	A unique claim/transaction number assigned by the state’s payment system that identifies the adjustment claim/transaction for an original item control number.
Mandatory	Indicates the type of adjustment record.
Mandatory	The date that the payment or recoupment was executed by the payer.
Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.

Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.
Conditional	The check or electronic funds transfer number.
Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped.
Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.
Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".
Conditional	This describes the type of managed care plan or care coordination model of the payer, when applicable. The valid value list is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.
Conditional	This is a description of what type of managed care plan or care coordination model the payer ID was reported with a PAYER-MCR-PLAN-OR-OTHER-TYPE of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.

Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.
Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".
Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.
Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".
Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.
Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.
Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".
Conditional	Managed care plan contract ID
Conditional	The state-assigned identification number of the Third Party Liability (TPL) Entity.

Conditional	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique “key” value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	The date representing the start of the time period that the payment is expected to be used by the provider.
Mandatory	The date representing the end of the time period that the payment is expected to be used by the provider.
Mandatory	A qualifier that identifies what the payment period begin and end dates represent. For example, the payment period begin an end dates may correspond to a range of service dates from claims or encounters or they may represent a period of beneficiary eligibility or enrollment.
Conditional	This is a description of the type of financial transaction when the PAYMENT-PERIOD-TYPE is "Other".
Conditional	This is a code that classifies the type of financial transaction when the financial transaction does not fit into any other financial transaction segment type (e.g., FTX00002, FTX00003, FTX00004, etc.).
Conditional	This is a description of the type of financial transaction when the TRANSACTION-TYPE is "Other".
Mandatory	A code to indicate the Federal funding source for the payment.
Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).

Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.
Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.
Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.
Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.
Mandatory	A code to indicate the source of non-federal share funds.

Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.
Mandatory	Indicates whether the financial transaction from an MC plan to a provider or other entity is a type of State Directed Payment.
Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.
Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types
Conditional	Cross-reference to the applicable payment category in the managed care plan's contract with the state Medicaid/CHIP agency or their fiscal intermediary.
Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.
Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.
Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.
Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.
Mandatory	Denotes which supported file encoding standard was used to create the file.
Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file.
Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	The date on which the file was created.
Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.
Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.

Mandatory	A code to indicate whether the records in the file are test or production records.
Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.
Mandatory	The file submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit the file. This should correspond with the state's declared file submission method for the same file type and time period.
Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e., update files, replacement files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The ID number a state issues to a managed care entity
Mandatory	The start date of the managed care contract period with the state.

Mandatory	The expiration date of the managed care contract period with the state.
Mandatory	The name of the managed care entity under contract with the State Medicaid Agency. The name should be as it appears on the contract.
Mandatory	The state program through which a managed care plan is approved to operate.
Mandatory	The type of managed care plan that corresponds to the State Plan Identification Number. The value reported in this data element should match the Managed Care Plan Type value reported on the Eligible file for the corresponding managed care plan number. Assign plan type value "15" for plans that primarily cover non-emergency medical transportation (NEMT). See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Non-Emergency Medical Transportation (NEMT) Prepaid Ambulatory Health Plans (PAHPs) in the T-MSIS Managed Care File" https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-nonemergency-medical-transportation-nemt-prepaid-ambulatory-health-plans-pahps-in-the-tmsis-managed-care-filemanaged-care/ See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Care Plan Type in the T-MSIS Managed Care File" https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareplantype-in-the-t-msis-managed-care-file-managed-care/
Mandatory	A code indicating the how the managed care entity is reimbursed.
Mandatory	A code denoting the profit status of managed care entity.

Mandatory	A code signifying whether the Managed Care Organization's (MCO) service area falls into one or more metropolitan or micropolitan statistical areas. Whenever a service area straddles two types of areas (e.g., metropolitan and micropolitan, metropolitan and non-CBSA area) classify the service area based on the denser classification. Metropolitan and micropolitan statistical areas (metro and micro areas) are geographic entities defined by the U.S. Office of Management and Budget (OMB). The term "Core Based Statistical Area" (CBSA) is a collective term for both metro and micro areas. A metro area contains a core urban area of 50,000 or more population, and a micro area contains an urban core of at least 10,000 (but less than 50,000) population. Each metro or micro area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core. The U.S. Office of Management and Budget (OMB) defines metropolitan or micropolitan statistical areas based on published standards. The standards for defining the areas are reviewed and revised once every ten years, prior to each decennial census. Between censuses, the definitions are updated annually to reflect the most recent Census Bureau population estimates. The current definitions are as of December 2009. See the hyperlink below for further information. http://www.whitehouse.gov/sites/default/files/omb/assets/bulletins/b10-02.pdf
Mandatory	The percentage of the managed care entity's total revenue that is derived from contracts with Medicare (Part C and D) in the state and State Medicaid agency contract(s) prior calendar year. Include Medicaid and Medicare in calculation of percentage of business in public programs for IRS health insurer tax exemption as required in ACA.
Mandatory	Identifies the geographic unit under which the managed care entity is under contract to provide services. The value reported in Managed Care Service Area should represent the geographical unit of the values reported in the Managed Care Service Area Name. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Care Service Area in the Managed Care File". https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareservicearea-in-the-managed-care-file-managed-care/
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.

Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The ID number a state issues to a managed care entity
Mandatory	A field to differentiate a managed care entity's service locations through adding a sequential number in this data element identifier field. Use sequential numbers to indicate additional services locations.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The type of address for the managed care organization submitted in the Managed Care Main segment.

Mandatory	The managed care entity's address listed on the contract with the state.
Conditional	The managed care entity's address listed on the contract with the state.
Conditional	The managed care entity's address listed on the contract with the state.
Mandatory	The city component of an address associated with a given entity (e.g. person, organization, agency, etc.).
Mandatory	The ANSI state numeric code for the U.S. state, Territory, or the District of Columbia code of the of the managed care entity's address as listed on the contract with the state.
Mandatory	U.S. ZIP Code component of an address associated with a given entity (e.g. person, organization, agency, etc.)
Mandatory	The ANSI County numeric code for the county or county equivalent. One county code should be captured for each of a managed care entity's locations identified.
Situational	Phone number for a given entity (e.g. person, organization, agency).
Situational	The email address of the managed care entity listed on the contract with the state.
Conditional	A fax number, including area code, as listed on the contract with the state.

Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The ID number a state issues to a managed care entity
Conditional	The specific identifiers for the counties, cities, regions, ZIP Codes and/or other geographic areas that the managed care entity serves. Put each zip code, city, county, region, or other area descriptor on a separate record. Use 5 digit zip codes when service area definition is zip code based. Use ANSI codes when service area is defined by counties or cities. The value reported in Managed Care Service Area should represent the geographical unit of the values reported in the Managed Care Service Area Name. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Care Service Area in the Managed Care File". https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareservicearea-in-the-managed-care-file-managed-care/
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.

Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The ID number a state issues to a managed care entity
Mandatory	The type of operating authority through which the managed care entity receives its contract authority. The Managed Care Plan Type assigned to the manage care plan in the Managed Care Main segment should be consistent with the Operating Authority value reported. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Care Plan Type in the T-MSIS Managed Care File". https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareplantype-in-the-t-msis-managed-care-file-managed-care/
Mandatory	Field specifying the ID of the waiver, demonstration or other authority which authorizes the state to operate the managed care program. These IDs must be the approved, full federal ID number assigned during the state submission and CMS approval process.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.

Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The ID number a state issues to a managed care entity
Mandatory	The eligibility group(s) the state is authorized to enroll in managed care plans by its operating authority. Submit a separate record segment for each eligibility group that can be enrolled in the managed care program in which the managed care plan is participating.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The ID number a state issues to a managed care entity
Mandatory	Identify the accreditation awarded to the managed care entity.
Mandatory	The date the organization achieved accreditation.
Mandatory	The date when organization's accreditation ends.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.

Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The ID number a state issues to a managed care entity
Mandatory	A code to identify the kind of managed care identifier that is captured in the Managed Care Identifier data element. The state should submit updates to T-MSIS whenever an identifier is retired or issued.
Mandatory	A data element to capture the various IDs used to identify a managed care plan. The specific type of identifier is defined in the corresponding value in the Managed Care Plan Identifier Type data element.
Mandatory	The date the organization achieved accreditation.
Mandatory	The date when organization's accreditation ends.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.
Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.
Mandatory	Denotes which supported file encoding standard was used to create the file.
Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file.

Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	The date on which the file was created.
Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.
Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.
Mandatory	A code to indicate whether the records in the file are test or production records.
Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.
Mandatory	The file submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit the file. This should correspond with the state's declared file submission method for the same file type and time period.
Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e., update files, replacement files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).

Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Conditional	The provider's name that is commonly used by the public when the "doing-business-as" name is different than the legal name. DBA is an abbreviation for "doing business as." Registering a DBA is required to operate a business under a name that differs from the company's legal name. If DBA name is the same as the legal name, do not populate DBA name.
Mandatory	The name as it appears on the provider agreement between the state and the entity. Both persons and other entities can have a legal name.
Conditional	The name of the provider when the provider is an organization. If the provider organization name exceeds 60 characters submit only the first 60 characters of the name. Provider Organization Name should be same as provider last name when provider is an individual.

Mandatory	The name that the provider entity uses on IRS filings.
Mandatory	A code to identify whether the Submitting State Provider Identifier is assigned to an individual, group, or a facility.
Conditional	A code indicating if the provider's organization is a teaching facility.
Conditional	Individual's first name; first name component of full name (e.g. First Name, Middle Initial, Last Name).
Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).
Conditional	Individual's last name; last name component of full name (e.g. First Name, Middle Initial, Last Name).
Conditional	Either individual's biological sex or their self-identified sex.
Conditional	A code denoting the ownership interest and/or managing control information. The valid values list is a Medicare standard list.

Mandatory	A code denoting the profit status of the provider.
Conditional	An individual's date of birth.
Conditional	The date an individual died on.
Mandatory	An indicator to identify providers who are accepting new patients.
Mandatory	An indicator to identify whether the provider is an atypical provider and therefore not eligible for an NPI.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.

Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location and Contact Info (PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the PRV.004 or PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The type of address and contact information for the provider submitted in the record segment.
Mandatory	The first line of a potentially multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).
Conditional	The second line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).
Conditional	The third line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).
Mandatory	The city component of an address associated with a given entity (e.g. person, organization, agency, etc.).

Mandatory	The ANSI numeric state code component of an address associated with a given entity (e.g. person, organization, agency, etc.)
Mandatory	U.S. ZIP Code component of an address associated with a given entity (e.g. person, organization, agency, etc.)
Situational	Phone number for a given entity (e.g. person, organization, agency).
Situational	The email address of the provider for the location being captured on this record
Situational	The fax number of the provider for the location being captured on this record.
Mandatory	A code identify an out of state provider enrolled with the state (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)
Mandatory	Standard ANSI code used to identify a specific U.S. County.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.

Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.
Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location and Contact Info (PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the PRV.004 or PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Mandatory	A code to identify the kind of license or accreditation number that is captured in the License or Accreditation Number data element.
Mandatory	A free text field to capture the identity of the entity issuing the license or accreditation. Enter the applicable state code, county code, municipality name, "DEA", professional society's name, or the CLIA accreditation body's name. -If associated License Type is equal to 1 and issuing authority is a State, then value must be ANSI State abbreviation code.- If associated License Type is equal to 1 and issuing authority is a county, then value must be a 5-digit, concatenated code consisting of the ANSI state code plus the ANSI county code. A list of codes can be found here: https://www.nrcs.usda.gov/wps/portal/nrcs/detail/national/home/?cid=nrcs143_013697 If associated License Type is equal to 1 and issuing authority is a municipality, then enter a text string with the name of the municipality. If associated License Type is equal to 3, then enter the text string identifying the professional society issuing the accreditation. If associated License Type is equal to 4, then value must be the text string identifying the CLIA accreditation body's name.

Mandatory	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body identified in the License Issuing Entity ID data element.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.
Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location and Contact Info (PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the PRV.004 or PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.
Mandatory	A code to identify the kind of provider identifier that is captured in the Provider Identifier data element. The state should submit updates to T-MSIS whenever an identifier is retired or issued. see Provider Identifier Type List (VVL.146)

Mandatory	A free text field to capture the identity of the entity that issued the provider identifier in the Provider Identifier (PRV.005.081) data element. For (State Tax ID), if associated Provider Identifier Type (PRV.005.077) value is equal to 6, then value must be the name of the state's taxation division. For (Other), if associated Provider Identifier Type (PRV.005.077) value is equal to 8, then value must be the name of the entity that issued the identifier.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Mandatory	A data element to capture the various ways used to distinguish providers from one another on claims and other interactions between providers and other entities. The specific type of identifier is defined in the corresponding value in the Provider Identifier Type data element.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).

Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.
Mandatory	A code to identify the schema used in the Provider Classification Code field to categorize providers. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Provider Classification Type and Provider Classification Code in the T-MSIS Provider File". https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/cms-technical-instructions-provider-classification-requirements-in-tmsis/ A provider may be reported with multiple active record segments with the same Provider Classification Type if different Provider Classification Code values apply.
Mandatory	The code values from the categorization schema identified in the Provider Classification Type data element. Note: States should apply these classification schemas consistently across all providers.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Mandatory	A code representing the provider's Medicaid and/or CHIP enrollment status for the time span specified by the Provider Medicaid Effective Date and Provider Medicaid End Date data elements. Note: The State Plan Enrollment data element identifies whether the provider is enrolled in Medicaid, CHIP, or both.
Mandatory	The state plan with which a provider has an affiliation and is able to provide services to the state's fee for service enrollees.
Mandatory	Process by which a provider was enrolled in Medicaid or CHIP.
Mandatory	The date on which the provider applied for enrollment into the State's Medicaid and/or CHIP program.

Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.
Mandatory	The unique, state-assigned identification number for the group or subpart with which the individual or subpart is associated. (The submitting state's unique identifier for the group. (Note: The group will also be in the provider data set as a provider (i.e., the group-as-a-provider).
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.
Mandatory	A code to identify the category of program that the provider is affiliated.
Mandatory	A data element to identify the Medicaid/CHIP programs, waivers and demonstrations in which the provider participates.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.

Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.
Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location and Contact Info (PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the PRV.004 or PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Mandatory	A code to classify beds available at a facility.

Mandatory	A count of the number of beds available at the facility for the category of bed identified in the Bed Type Code data element. Beds should not be counted twice under different bed types. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Provider Bed Information in the T-MSIS Provider File". https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-provider-bed-information-in-the-tmsis-provider-file-provider/
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.
Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.
Mandatory	Denotes which supported file encoding standard was used to create the file.
Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file.
Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	The date on which the file was created.

Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.
Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.
Mandatory	A code to indicate whether the records in the file are test or production records.
Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.
Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.
Mandatory	The file submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit the file. This should correspond with the state's declared file submission method for the same file type and time period.
Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e., update files, replacement files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).

Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Mandatory	A flag to indicate that the Medicaid/CHIP eligible person has some form of third party insurance coverage.
Mandatory	A flag to indicate that the Medicaid/CHIP eligible person has some other form of third party funding besides insurance coverage.
Mandatory	The first name of the individual to whom the services were provided.
Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).
Mandatory	The last name of the individual to whom the services were provided.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.

Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/
Conditional	The state-assigned identification number of the Third Party Liability (TPL) Entity.
Conditional	The ID number issued by the Insurance carrier providing third party liability insurance coverage to beneficiaries. Typically the Plan ID/Plan Number is on the beneficiaries' insurance card.

Conditional	The group number of the TPL health insurance policy.
Conditional	Member identification number as it appears on the card issued by the TPL insurance carrier.
Conditional	Code to classify the type of insurance plan providing TPL coverage.
Conditional	Annual amount paid each year by the enrollee in the plan before a health plan benefit begins.
Mandatory	Individual's first name; first name component of full name (e.g. First Name, Middle Initial, Last Name).
Mandatory	Individual's last name; last name component of full name (e.g. First Name, Middle Initial, Last Name).
Conditional	Unique identifier issued to an individual by the SSA for the purpose of identification.
Conditional	This code identifies the relationship of the policy holder to the Medicaid/CHIP beneficiary.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.

Mandatory	A code to indicate the level of coverage being provided under this policy for the insured by the TPL carrier.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The state-assigned identification number of the Third Party Liability (TPL) Entity.
Mandatory	The ID number issued by the Insurance carrier providing third party liability insurance coverage to beneficiaries. Typically the Plan ID/Plan Number is on the beneficiaries' insurance card.
Mandatory	Code to classify the entity providing TPL coverage.
Mandatory	Code indicating the level of coverage being provided under this policy for the insured by the TPL carrier.

Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/

Mandatory	This code identifies the other types of liabilities an individual may have which are not necessarily defined as a health insurance plan listed Insurance Type Plan.
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	A free text field for the submitting state to enter whatever information it chooses.
Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).
Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.
Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.
Mandatory	The state-assigned identification number of the Third Party Liability (TPL) Entity.
Mandatory	The type of address for a TPL Entity submitted in the record segment.

Situational	The first line of a potentially multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).
Conditional	The second line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).
Conditional	The third line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).
Situational	The city component of an address associated with a given entity (e.g. person, organization, agency, etc.).
Situational	The ANSI state numeric code for the U.S. state, Territory, or the District of Columbia code of the TPL Insurance carrier.
Situational	The ZIP Code for the location being captured on the TPL Entity Contact Information record.
Situational	Phone number for a given entity (e.g. person, organization, agency).
Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.
Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.
Situational	The National Association of Insurance Commissioners (NAIC) code of the TPL Insurance carrier.

Situational	The name of the TPL Insurance carrier.
Situational	A free text field for the submitting state to enter whatever information it chooses.

g starting with "FTX"

Valid Value List (VVL)	File Segment Number	File Segment Name	Size	Pipe Separated Value Segment Data Element Order
RECORD-ID	CIP00001	FILE-HEADER-RECORD-IP	X(8)	1
DATA-DICTIONARY-VERSION	CIP00001	FILE-HEADER-RECORD-IP	X(10)	2
SUBMISSION-TRANSACTION-TYPE	CIP00001	FILE-HEADER-RECORD-IP	X(1)	3
FILE-ENCODING-SPECIFICATION	CIP00001	FILE-HEADER-RECORD-IP	X(3)	4
N/A	CIP00001	FILE-HEADER-RECORD-IP	X(9)	5

N/A	CIP00001	FILE-HEADER-RECORD-IP	X(8)	6
STATE	CIP00001	FILE-HEADER-RECORD-IP	X(2)	7
N/A	CIP00001	FILE-HEADER-RECORD-IP	9(8)	8
N/A	CIP00001	FILE-HEADER-RECORD-IP	9(8)	9
N/A	CIP00001	FILE-HEADER-RECORD-IP	9(8)	10
FILE-STATUS-INDICATOR	CIP00001	FILE-HEADER-RECORD-IP	X(1)	11
SSN-INDICATOR	CIP00001	FILE-HEADER-RECORD-IP	X(1)	12
N/A	CIP00001	FILE-HEADER-RECORD-IP	9(11)	13

N/A	CIP00001	FILE-HEADER-RECORD-IP	X(4)	14
N/A	CIP00001	FILE-HEADER-RECORD-IP	X(500)	15
RECORD-ID	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	1
STATE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	2
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(11)	3
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(50)	4
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(50)	5
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	6

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(20)	7
CROSSOVER-INDICATOR	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	8
TYPE-OF-HOSPITAL	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	9
1115A-DEMONSTRATION-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	10
ADJUSTMENT-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	11
ADJUSTMENT-REASON-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(3)	12
ADMISSION-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	13
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(20)	14

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(4)	15
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(4)	16
PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	17
PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	18
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	19

PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	20
PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	21
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	22
PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	23
PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	24

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	25
PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	26
PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	27
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	28
PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	29

PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	30
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	31
PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	32
PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	33
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	34

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	35
HOUR	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	36
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	37
HOUR	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	38
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	39
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	40
TYPE-OF-CLAIM	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	41

TYPE-OF-BILL	CIP00002	CLAIM-HEADER-RECORD-IP	X(4)	42
CLAIM-STATUS	CIP00002	CLAIM-HEADER-RECORD-IP	X(3)	43
CLAIM-STATUS-CATEGORY	CIP00002	CLAIM-HEADER-RECORD-IP	X(3)	44
SOURCE-LOCATION	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	45
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(15)	46
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	47

CLAIM-PYMT-REM-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(5)	48
CLAIM-PYMT-REM-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(5)	49
CLAIM-PYMT-REM-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(5)	50
CLAIM-PYMT-REM-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(5)	51

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	52
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	53
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	54

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	55
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	56
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	57
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	58
OTHER-INSURANCE-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	59
OTHER-TPL-COLLECTION	CIP00002	CLAIM-HEADER-RECORD-IP	X(3)	60

FIXED-PAYMENT-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	61
FUNDING-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	62
FUNDING-SOURCE-NONFEDERAL-SHARE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	63
MEDICARE-COMB-DED-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	64
PROGRAM-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	65

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	66
PAYMENT-LEVEL-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	67
MEDICARE-REIM-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	68

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(5)	69
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	70
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(7)	71
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(4)	72
FORCED-CLAIM-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	73
HEALTH-CARE-ACQUIRED-CONDITION-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	74
OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	75
OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	76

OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	77
OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	78
OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	79
OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	80
OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	81
OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	82
OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	83
OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	84
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	85
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	86

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	87
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	88
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	89
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	90
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	91
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	92
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	93
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	94
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	95

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	96
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	97
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	98
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	99
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	100
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	101
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	102
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	103
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	104
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(6)V999	105
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(20)	106

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	107
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	108
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	109
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	110
HEALTH-HOME-PROV-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	111
WAIVER-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	112
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(20)	113

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	114
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(10)	115
PROV-TAXONOMY	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	116
PROV-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	117
PROV-SPECIALTY	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	118
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(10)	119
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	120
PROV-SPECIALTY	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	121

PROV-TAXONOMY	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	122
PROV-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	123
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	124
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(10)	125
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	126
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(3)V99999	127
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	128

OUTLIER-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	129
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(5)	130
PATIENT-STATUS	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	131
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	132
SPLIT-CLAIM-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	133
BORDER-STATE-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	134
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	135
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	136
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	137
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	138

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	139
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	140
CLAIM-DENIED-INDICATOR	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	141
COPAY-WAIVED-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	142
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(50)	143
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	144
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	145
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	146
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	147

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	148
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(10)	149
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	150
PROV-TAXONOMY	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	151
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	152

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(5)	153
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	154
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	155
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	156
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	157

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	158
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	159
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	160
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(60)	161
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(60)	162
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(28)	163
STATE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	164
ZIP-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(9)	165
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(10)	166
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(60)	167

N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(60)	168
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(28)	169
STATE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	170
ZIP-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(9)	171
PROVIDER-CLAIM-FORM-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	172
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(50)	173
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	174
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	175
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	176
N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(500)	177

RECORD-ID	CIP00003	CLAIM-LINE-RECORD-IP	X(8)	1
STATE	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	2
N/A	CIP00003	CLAIM-LINE-RECORD-IP	9(11)	3
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(20)	4
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(50)	5
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(50)	6
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	7

N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	8
LINE-ADJUSTMENT-IND	CIP00003	CLAIM-LINE-RECORD-IP	X(1)	9
LINE-ADJUSTMENT-REASON-CODE	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	10
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(12)	11
CLAIM-STATUS	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	12
N/A	CIP00003	CLAIM-LINE-RECORD-IP	9(8)	13

N/A	CIP00003	CLAIM-LINE-RECORD-IP	9(8)	14
REVENUE-CODE	CIP00003	CLAIM-LINE-RECORD-IP	X(4)	15
N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(6)V999	16
N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(6)V999	17

N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	18
N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	19
N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	20
N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	21

BILLING-UNIT	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	22
TYPE-OF-SERVICE-IP	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	23
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(30)	24
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(10)	25
PROV-TYPE	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	26
PROV-SPECIALTY	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	27
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(10)	28
OTHER-TPL-COLLECTION	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	29
PROV-FACILITY-TYPE	CIP00003	CLAIM-LINE-RECORD-IP	X(9)	30

CATEGORY-FOR-FEDERAL-REIMBURSEMENT	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	31
N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	32
N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(9)V(9)	33
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(12)	34
NDC-UNIT-OF-MEASURE	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	35
N/A	CIP00003	CLAIM-LINE-RECORD-IP	9(8)	36
SELF-DIRECTION-TYPE	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	37
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(18)	38
IHS-SERVICE-IND	CIP00003	CLAIM-LINE-RECORD-IP	X(1)	39
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(76)	40

MBESCBES-FORM-GROUP	CIP00003	CLAIM-LINE-RECORD-IP	X(1)	41
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	CIP00003	CLAIM-LINE-RECORD-IP	X(50)	42
21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	CIP00003	CLAIM-LINE-RECORD-IP	X(5)	43
N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	44

N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(30)	45
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(10)	46
N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	47
N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	48
N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(500)	49
RECORD-ID	CIP00004	CLAIM-DX-IP	X(8)	1
STATE	CIP00004	CLAIM-DX-IP	X(2)	2
N/A	CIP00004	CLAIM-DX-IP	9(11)	3
N/A	CIP00004	CLAIM-DX-IP	X(50)	4

N/A	CIP00004	CLAIM-DX-IP	X(50)	5
ADJUSTMENT-IND	CIP00004	CLAIM-DX-IP	X(1)	6
N/A	CIP00004	CLAIM-DX-IP	9(8)	7
DIAGNOSIS-TYPE	CIP00004	CLAIM-DX-IP	X(1)	8
N/A	CIP00004	CLAIM-DX-IP	9(2)	9
DIAGNOSIS-CODE-FLAG	CIP00004	CLAIM-DX-IP	X(1)	10
DIAGNOSIS-CODE	CIP00004	CLAIM-DX-IP	X(7)	11

DIAGNOSIS-POA-FLAG	CIP00004	CLAIM-DX-IP	X(1)	12
N/A	CIP00004	CLAIM-DX-IP	X(500)	13
RECORD-ID	CLT00001	FILE-HEADER-RECORD-LT	X(8)	1
DATA-DICTIONARY-VERSION	CLT00001	FILE-HEADER-RECORD-LT	X(10)	2
SUBMISSION-TRANSACTION-TYPE	CLT00001	FILE-HEADER-RECORD-LT	X(1)	3
FILE-ENCODING-SPECIFICATION	CLT00001	FILE-HEADER-RECORD-LT	X(3)	4
N/A	CLT00001	FILE-HEADER-RECORD-LT	X(9)	5
N/A	CLT00001	FILE-HEADER-RECORD-LT	X(8)	6
STATE	CLT00001	FILE-HEADER-RECORD-LT	X(2)	7

N/A	CLT00001	FILE-HEADER-RECORD-LT	9(8)	8
N/A	CLT00001	FILE-HEADER-RECORD-LT	9(8)	9
N/A	CLT00001	FILE-HEADER-RECORD-LT	9(8)	10
FILE-STATUS-INDICATOR	CLT00001	FILE-HEADER-RECORD-LT	X(1)	11
SSN-INDICATOR	CLT00001	FILE-HEADER-RECORD-LT	X(1)	12
N/A	CLT00001	FILE-HEADER-RECORD-LT	9(11)	13
N/A	CLT00001	FILE-HEADER-RECORD-LT	X(4)	14
N/A	CLT00001	FILE-HEADER-RECORD-LT	X(500)	15

RECORD-ID	CLT00002	CLAIM-HEADER-RECORD-LT	X(8)	1
STATE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	2
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(11)	3
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(50)	4
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(50)	5
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	6
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(20)	7

CROSSOVER-INDICATOR	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	8
1115A-DEMONSTRATION-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	9
ADJUSTMENT-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	10
ADJUSTMENT-REASON-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(3)	11
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	12
HOUR	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	13

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	14
HOUR	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	15
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	16
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	17
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	18
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	19

TYPE-OF-CLAIM	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	20
TYPE-OF-BILL	CLT00002	CLAIM-HEADER-RECORD-LT	X(4)	21
CLAIM-STATUS	CLT00002	CLAIM-HEADER-RECORD-LT	X(3)	22
CLAIM-STATUS-CATEGORY	CLT00002	CLAIM-HEADER-RECORD-LT	X(3)	23
SOURCE-LOCATION	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	24
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(15)	25
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	26

CLAIM-PYMT-REM-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(5)	27
CLAIM-PYMT-REM-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(5)	28
CLAIM-PYMT-REM-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(5)	29
CLAIM-PYMT-REM-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(5)	30

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	31
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	32
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	33

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	34
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	35
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	36
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	37
OTHER-INSURANCE-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	38
OTHER-TPL-COLLECTION	CLT00002	CLAIM-HEADER-RECORD-LT	X(3)	39

FIXED-PAYMENT-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	40
FUNDING-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	41
FUNDING-SOURCE-NONFEDERAL-SHARE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	42
MEDICARE-COMB-DED-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	43
PROGRAM-TYPE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	44

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	45
PAYMENT-LEVEL-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	46

MEDICARE-REIM-TYPE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	47
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(5)	48
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	49
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(5)	50
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(4)	51
FORCED-CLAIM-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	52
HEALTH-CARE-ACQUIRED-CONDITION-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	53
OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	54

OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	55
OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	56
OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	57
OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	58
OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	59
OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	60
OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	61
OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	62
OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	63
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	64

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	65
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	66
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	67
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	68
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	69
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	70
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	71
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	72
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	73

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	74
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	75
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	76
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	77
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	78
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	79
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	80
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	81
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	82
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	83
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(20)	84

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	85
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	86
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	87
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	88
HEALTH-HOME-PROV-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	89
WAIVER-TYPE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	90
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(20)	91

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	92
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(10)	93
PROV-TAXONOMY	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	94
PROV-TYPE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	95
PROV-SPECIALTY	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	96
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	97
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(10)	98

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	99
PATIENT-STATUS	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	100
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	101
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	102
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(5)	103
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(5)	104

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(5)	105
SPLIT-CLAIM-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	106
BORDER-STATE-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	107
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	108
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	109
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	110
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	111
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	112
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	113

CLAIM-DENIED-INDICATOR	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	114
COPAY-WAIVED-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	115
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(50)	116
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	117
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	118
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	119
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	120
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	121

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	122
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(10)	123
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	124
PROV-SPECIALTY	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	125
PROV-TAXONOMY	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	126
PROV-TYPE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	127
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	128

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(5)	129
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	130
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	131
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	132
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	133
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(60)	134
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(60)	135
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(28)	136
STATE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	137

ZIP-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(9)	138
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(10)	139
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(60)	140
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(60)	141
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(28)	142
STATE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	143
ZIP-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(9)	144
PROVIDER-CLAIM-FORM-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	145
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(50)	146
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	147

N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	148
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	149
N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(500)	150
RECORD-ID	CLT00003	CLAIM-LINE-RECORD-LT	X(8)	1
STATE	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	2
N/A	CLT00003	CLAIM-LINE-RECORD-LT	9(11)	3
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(20)	4

N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(50)	5
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(50)	6
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	7
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	8
LINE-ADJUSTMENT-IND	CLT00003	CLAIM-LINE-RECORD-LT	X(1)	9
LINE-ADJUSTMENT-REASON-CODE	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	10
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(12)	11
CLAIM-STATUS	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	12

N/A	CLT00003	CLAIM-LINE-RECORD-LT	9(8)	13
N/A	CLT00003	CLAIM-LINE-RECORD-LT	9(8)	14
REVENUE-CODE	CLT00003	CLAIM-LINE-RECORD-LT	X(4)	15
N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(6)V999	16

N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(6)V999	17
N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	18
N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	19
N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	20

N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	21
N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	22
N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	23
BILLING-UNIT	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	24
TYPE-OF-SERVICE-LT	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	25
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(30)	26
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(10)	27
PROV-TYPE	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	28

PROV-SPECIALTY	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	29
OTHER-TPL-COLLECTION	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	30
CATEGORY-FOR-FEDERAL-REIMBURSEMENT	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	31
PROV-FACILITY-TYPE	CLT00003	CLAIM-LINE-RECORD-LT	X(9)	32
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(12)	33
NDC-UNIT-OF-MEASURE	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	34
N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(9)V(9)	35
N/A	CLT00003	CLAIM-LINE-RECORD-LT	9(8)	36
SELF-DIRECTION-TYPE	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	37
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(18)	38
IHS-SERVICE-IND	CLT00003	CLAIM-LINE-RECORD-LT	X(1)	39

N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(76)	40
MBESCBES-FORM-GROUP	CLT00003	CLAIM-LINE-RECORD-LT	X(1)	41
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	CLT00003	CLAIM-LINE-RECORD-LT	X(50)	42
21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	CLT00003	CLAIM-LINE-RECORD-LT	X(5)	43
N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	44

N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(30)	45
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(10)	46
N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	47
N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	48
N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(500)	49
RECORD-ID	CLT00004	CLAIM-DX-LT	X(8)	1
STATE	CLT00004	CLAIM-DX-LT	X(2)	2
N/A	CLT00004	CLAIM-DX-LT	9(11)	3
N/A	CLT00004	CLAIM-DX-LT	X(50)	4

N/A	CLT00004	CLAIM-DX-LT	X(50)	5
ADJUSTMENT-IND	CLT00004	CLAIM-DX-LT	X(1)	6
N/A	CLT00004	CLAIM-DX-LT	9(8)	7
DIAGNOSIS-TYPE	CLT00004	CLAIM-DX-LT	X(1)	8
N/A	CLT00004	CLAIM-DX-LT	9(2)	9
DIAGNOSIS-CODE-FLAG	CLT00004	CLAIM-DX-LT	X(1)	10
DIAGNOSIS-CODE	CLT00004	CLAIM-DX-LT	X(7)	11

DIAGNOSIS-POA-FLAG	CLT00004	CLAIM-DX-LT	X(1)	12
N/A	CLT00004	CLAIM-DX-LT	X(500)	13
RECORD-ID	COT00001	FILE-HEADER-RECORD-OT	X(8)	1
DATA-DICTIONARY-VERSION	COT00001	FILE-HEADER-RECORD-OT	X(10)	2
SUBMISSION-TRANSACTION-TYPE	COT00001	FILE-HEADER-RECORD-OT	X(1)	3
FILE-ENCODING-SPECIFICATION	COT00001	FILE-HEADER-RECORD-OT	X(3)	4
N/A	COT00001	FILE-HEADER-RECORD-OT	X(9)	5
N/A	COT00001	FILE-HEADER-RECORD-OT	X(8)	6
STATE	COT00001	FILE-HEADER-RECORD-OT	X(2)	7

N/A	COT00001	FILE-HEADER-RECORD-OT	9(8)	8
N/A	COT00001	FILE-HEADER-RECORD-OT	9(8)	9
N/A	COT00001	FILE-HEADER-RECORD-OT	9(8)	10
FILE-STATUS-INDICATOR	COT00001	FILE-HEADER-RECORD-OT	X(1)	11
SSN-INDICATOR	COT00001	FILE-HEADER-RECORD-OT	X(1)	12
N/A	COT00001	FILE-HEADER-RECORD-OT	9(11)	13
N/A	COT00001	FILE-HEADER-RECORD-OT	X(4)	14
N/A	COT00001	FILE-HEADER-RECORD-OT	X(500)	15

RECORD-ID	COT00002	CLAIM-HEADER-RECORD-OT	X(8)	1
STATE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	2
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(11)	3
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(50)	4
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(50)	5
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(12)	6
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(20)	7

CROSSOVER-INDICATOR	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	8
1115A-DEMONSTRATION-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	9
ADJUSTMENT-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	10
ADJUSTMENT-REASON-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(3)	11
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	12

N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	13
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	14
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	15
TYPE-OF-CLAIM	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	16
TYPE-OF-BILL	COT00002	CLAIM-HEADER-RECORD-OT	X(4)	17
CLAIM-STATUS	COT00002	CLAIM-HEADER-RECORD-OT	X(3)	18
CLAIM-STATUS-CATEGORY	COT00002	CLAIM-HEADER-RECORD-OT	X(3)	19

SOURCE-LOCATION	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	20
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(15)	21
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	22
CLAIM-PYMT-REM-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(5)	23
CLAIM-PYMT-REM-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(5)	24

CLAIM-PYMT-REM-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(5)	25
CLAIM-PYMT-REM-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(5)	26
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	27
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	28

N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	29
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	30
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	31
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	32

N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	33
OTHER-INSURANCE-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	34
OTHER-TPL-COLLECTION	COT00002	CLAIM-HEADER-RECORD-OT	X(3)	35
FIXED-PAYMENT-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	36
FUNDING-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	37
FUNDING-SOURCE-NONFEDERAL-SHARE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	38
MEDICARE-COMB-DED-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	39

PROGRAM-TYPE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	40
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(12)	41

PAYMENT-LEVEL-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	42
MEDICARE-REIM-TYPE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	43
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(4)	44
FORCED-CLAIM-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	45

HEALTH-CARE-ACQUIRED-CONDITION-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	46
OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	47
OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	48
OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	49
OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	50
OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	51
OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	52
OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	53
OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	54
OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	55
OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	56

N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	57
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	58
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	59
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	60
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	61
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	62
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	63
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	64
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	65

N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	66
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	67
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	68
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	69
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	70
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	71
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	72
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	73
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	74
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	75
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	76

N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(20)	77
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	78
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	79
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	80
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	81
HEALTH-HOME-PROV-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	82
WAIVER-TYPE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	83
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(20)	84

N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	85
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(10)	86
PROV-TAXONOMY	COT00002	CLAIM-HEADER-RECORD-OT	X(12)	87
PROV-TYPE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	88
PROV-SPECIALTY	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	89
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	90
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(10)	91

N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(12)	92
PLACE-OF-SERVICE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	93
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	94
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(5)V99	95
BORDER-STATE-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	96
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	97
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	98
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	99
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	100
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	101

N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	102
CLAIM-DENIED-INDICATOR	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	103
COPAY-WAIVED-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	104
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(50)	105
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	106
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	107
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	108
N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	109
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(10)	110

N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(12)	111
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(5)	112
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	113
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	114
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	115

N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	116
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	117
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(60)	118
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(60)	119
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(28)	120
STATE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	121
ZIP-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(9)	122
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(10)	123
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(60)	124

N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(60)	125
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(28)	126
STATE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	127
ZIP-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(9)	128
PROVIDER-CLAIM-FORM-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	129
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(50)	130
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	131
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	132
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(10)	133

N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	134
N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	135
N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(500)	136
RECORD-ID	COT00003	CLAIM-LINE-RECORD-OT	X(8)	1
STATE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	2
N/A	COT00003	CLAIM-LINE-RECORD-OT	9(11)	3
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(20)	4
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(50)	5

N/A	COT00003	CLAIM-LINE-RECORD-OT	X(50)	6
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(3)	7
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(3)	8
LINE-ADJUSTMENT-IND	COT00003	CLAIM-LINE-RECORD-OT	X(1)	9
LINE-ADJUSTMENT-REASON-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(3)	10
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(12)	11
CLAIM-STATUS	COT00003	CLAIM-LINE-RECORD-OT	X(3)	12

N/A	COT00003	CLAIM-LINE-RECORD-OT	9(8)	13
N/A	COT00003	CLAIM-LINE-RECORD-OT	9(8)	14
REVENUE-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(4)	15
PROCEDURE-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(8)	16

N/A	COT00003	CLAIM-LINE-RECORD-OT	9(8)	17
PROCEDURE-CODE-FLAG	COT00003	CLAIM-LINE-RECORD-OT	X(2)	18
PROCEDURE-CODE-MOD	COT00003	CLAIM-LINE-RECORD-OT	X(2)	19
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	20
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	21

N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	22
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	23
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	24
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	25
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	26
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(8)V999	27

N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(8)V999	28
TYPE-OF-SERVICE-OT	COT00003	CLAIM-LINE-RECORD-OT	X(3)	29
HCBS-SERVICE-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(1)	30

HCBS-TAXONOMY	COT00003	CLAIM-LINE-RECORD-OT	X(5)	31
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(30)	32
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(10)	33
PROV-TAXONOMY	COT00003	CLAIM-LINE-RECORD-OT	X(12)	34

PROV-TYPE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	35
PROV-SPECIALTY	COT00003	CLAIM-LINE-RECORD-OT	X(2)	36
OTHER-TPL-COLLECTION	COT00003	CLAIM-LINE-RECORD-OT	X(3)	37
TOOTH-DESIGNATION-SYSTEM	COT00003	CLAIM-LINE-RECORD-OT	X(2)	38
TOOTH-NUM	COT00003	CLAIM-LINE-RECORD-OT	X(2)	39
TOOTH-QUAD-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	40
TOOTH-SURFACE-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(1)	41
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	42

N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	43
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(28)	44
STATE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	45
ZIP-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(9)	46
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	47
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	48
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(28)	49
STATE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	50
ZIP-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(9)	51

CATEGORY-FOR-FEDERAL-REIMBURSEMENT	COT00003	CLAIM-LINE-RECORD-OT	X(2)	52
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	53
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(12)	54
PROCEDURE-CODE-MOD	COT00003	CLAIM-LINE-RECORD-OT	X(2)	55
PROCEDURE-CODE-MOD	COT00003	CLAIM-LINE-RECORD-OT	X(2)	56
PROCEDURE-CODE-MOD	COT00003	CLAIM-LINE-RECORD-OT	X(2)	57
N/A	COT00003	CLAIM-LINE-RECORD-OT	9(8)	58
SELF-DIRECTION-TYPE	COT00003	CLAIM-LINE-RECORD-OT	X(3)	59
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(18)	60

NDC-UNIT-OF-MEASURE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	61
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(9)V(9)	62
IHS-SERVICE-IND	COT00003	CLAIM-LINE-RECORD-OT	X(1)	63
N/A	COT00003	CLAIM-LINE-RECORD-OT	9(2)	64
N/A	COT00003	CLAIM-LINE-RECORD-OT	9(2)	65
N/A	COT00003	CLAIM-LINE-RECORD-OT	9(2)	66
N/A	COT00003	CLAIM-LINE-RECORD-OT	9(2)	67
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(76)	68
MBESCBES-FORM-GROUP	COT00003	CLAIM-LINE-RECORD-OT	X(1)	69
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	COT00003	CLAIM-LINE-RECORD-OT	X(50)	70

21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	COT00003	CLAIM-LINE-RECORD-OT	X(5)	71
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(10)	72
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	73
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	74
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(28)	75

STATE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	76
ZIP-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(9)	77
PLACE-OF-SERVICE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	78
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	79
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(30)	80
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(10)	81
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(30)	82

N/A	COT00003	CLAIM-LINE-RECORD-OT	X(10)	83
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(30)	84
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(10)	85
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	86
N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	87
N/A	COT00003	CLAIM-LINE-RECORD-OT	X(500)	88
RECORD-ID	COT00004	CLAIM-DX-OT	X(8)	1
STATE	COT00004	CLAIM-DX-OT	X(2)	2
N/A	COT00004	CLAIM-DX-OT	9(11)	3

N/A	COT00004	CLAIM-DX-OT	X(50)	4
N/A	COT00004	CLAIM-DX-OT	X(50)	5
ADJUSTMENT-IND	COT00004	CLAIM-DX-OT	X(1)	6
N/A	COT00004	CLAIM-DX-OT	9(8)	7
DIAGNOSIS-TYPE	COT00004	CLAIM-DX-OT	X(1)	8
N/A	COT00004	CLAIM-DX-OT	9(2)	9
DIAGNOSIS-CODE-FLAG	COT00004	CLAIM-DX-OT	X(1)	10

DIAGNOSIS-CODE	COT00004	CLAIM-DX-OT	X(7)	11
N/A	COT00004	CLAIM-DX-OT	X(500)	12
RECORD-ID	CRX00001	FILE-HEADER-RECORD-RX	X(8)	1
DATA-DICTIONARY-VERSION	CRX00001	FILE-HEADER-RECORD-RX	X(10)	2
SUBMISSION-TRANSACTION-TYPE	CRX00001	FILE-HEADER-RECORD-RX	X(1)	3
FILE-ENCODING-SPECIFICATION	CRX00001	FILE-HEADER-RECORD-RX	X(3)	4
N/A	CRX00001	FILE-HEADER-RECORD-RX	X(9)	5
N/A	CRX00001	FILE-HEADER-RECORD-RX	X(8)	6
STATE	CRX00001	FILE-HEADER-RECORD-RX	X(2)	7
N/A	CRX00001	FILE-HEADER-RECORD-RX	9(8)	8

N/A	CRX00001	FILE-HEADER-RECORD-RX	9(8)	9
N/A	CRX00001	FILE-HEADER-RECORD-RX	9(8)	10
FILE-STATUS-INDICATOR	CRX00001	FILE-HEADER-RECORD-RX	X(1)	11
SSN-INDICATOR	CRX00001	FILE-HEADER-RECORD-RX	X(1)	12
N/A	CRX00001	FILE-HEADER-RECORD-RX	9(11)	13
N/A	CRX00001	FILE-HEADER-RECORD-RX	X(4)	14
N/A	CRX00001	FILE-HEADER-RECORD-RX	X(500)	15
RECORD-ID	CRX00002	CLAIM-HEADER-RECORD-RX	X(8)	1

STATE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	2
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(11)	3
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(50)	4
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(50)	5
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(12)	6
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(20)	7
CROSSOVER-INDICATOR	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	8

1115A-DEMONSTRATION-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	9
ADJUSTMENT-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	10
ADJUSTMENT-REASON-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(3)	11
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	12
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	13
TYPE-OF-CLAIM	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	14
CLAIM-STATUS	CRX00002	CLAIM-HEADER-RECORD-RX	X(3)	15
CLAIM-STATUS-CATEGORY	CRX00002	CLAIM-HEADER-RECORD-RX	X(3)	16

SOURCE-LOCATION	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	17
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(15)	18
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	19
CLAIM-PYMT-REM-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(5)	20
CLAIM-PYMT-REM-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(5)	21

CLAIM-PYMT-REM-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(5)	22
CLAIM-PYMT-REM-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(5)	23
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	24
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	25

N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	26
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	27
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	28
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	29

N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	30
OTHER-INSURANCE-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	31
OTHER-TPL-COLLECTION	CRX00002	CLAIM-HEADER-RECORD-RX	X(3)	32
FIXED-PAYMENT-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	33
FUNDING-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	34
FUNDING-SOURCE-NONFEDERAL-SHARE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	35
PROGRAM-TYPE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	36

N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(12)	37
PAYMENT-LEVEL-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	38

MEDICARE-REIM-TYPE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	39
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(4)	40
FORCED-CLAIM-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	41
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(20)	42
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	43
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	44
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	45
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	46
HEALTH-HOME-PROV-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	47

WAIVER-TYPE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	48
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(20)	49
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	50
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(10)	51
PROV-TAXONOMY	CRX00002	CLAIM-HEADER-RECORD-RX	X(12)	52

PROV-SPECIALTY	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	53
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	54
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(10)	55
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(12)	56
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	57
BORDER-STATE-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	58
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	59

N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	60
COMPOUND-DRUG-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	61
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	62
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	63
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	64
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	65
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	66
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	67
CLAIM-DENIED-INDICATOR	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	68

COPAY-WAIVED-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	69
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(50)	70
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	71
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	72
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	73
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	74
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(10)	75
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(10)	76

N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(12)	77
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	78
MEDICARE-COMB-DED-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	79
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(5)	80
PRESCRIPTION-ORIGIN-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	81

N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	82
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	83
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	84
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	85
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	86
PROVIDER-CLAIM-FORM-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	87
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(50)	88
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	89
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	90

N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	91
N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(500)	92
RECORD-ID	CRX00003	CLAIM-LINE-RECORD-RX	X(8)	1
STATE	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	2
N/A	CRX00003	CLAIM-LINE-RECORD-RX	9(11)	3
N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(20)	4
N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(50)	5

N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(50)	6
N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	7
N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	8
LINE-ADJUSTMENT-IND	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	9
LINE-ADJUSTMENT-REASON-CODE	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	10
N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(12)	11
CLAIM-STATUS	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	12
N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(12)	13

N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	14
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	15
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(5)V99	16
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	17

N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	18
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	19
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	20
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	21
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	22

N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(9)V(9)	23
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(9)V(9)	24
NDC-UNIT-OF-MEASURE	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	25
TYPE-OF-SERVICE-RX	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	26
HCBS-SERVICE-CODE	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	27

HCBS-TAXONOMY	CRX00003	CLAIM-LINE-RECORD-RX	X(5)	28
OTHER-TPL-COLLECTION	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	29
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(5)	30
NEW-REFILL-IND	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	31
BRAND-GENERIC-IND	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	32

N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(6)V99	33
N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(12)	34
DRUG-UTILIZATION-CODE-E4, DRUG-UTILIZATION-CODE-E5, DRUG-UTILIZATION-CODE-E6	CRX00003	CLAIM-LINE-RECORD-RX	X(6)	35
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(7)V999	36
COMPOUND-DOSAGE-FORM	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	37
REBATE-ELIGIBLE-INDICATOR	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	38

CATEGORY-FOR-FEDERAL-REIMBURSEMENT	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	39
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	40
N/A	CRX00003	CLAIM-LINE-RECORD-RX	9(8)	41
SELF-DIRECTION-TYPE	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	42
N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(18)	43
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	44
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	45
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	46

N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	47
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	48
IHS-SERVICE-IND	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	49
N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(76)	50
MBESCBES-FORM-GROUP	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	51
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	CRX00003	CLAIM-LINE-RECORD-RX	X(50)	52

21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	CRX00003	CLAIM-LINE-RECORD-RX	X(5)	53
PROCEDURE-CODE	CRX00003	CLAIM-LINE-RECORD-RX	X(6)	54
PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	55
PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	56
PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	57
PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	58
PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	59

PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	60
PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	61
PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	62
PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	63
PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	64
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	65
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	66
N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	67
N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(500)	68
RECORD-ID	CRX00004	CLAIM-DX-RX	X(8)	1

STATE	CRX00004	CLAIM-DX-RX	X(2)	2
N/A	CRX00004	CLAIM-DX-RX	9(11)	3
N/A	CRX00004	CLAIM-DX-RX	X(50)	4
N/A	CRX00004	CLAIM-DX-RX	X(50)	5
ADJUSTMENT-IND	CRX00004	CLAIM-DX-RX	X(1)	6
N/A	CRX00004	CLAIM-DX-RX	9(8)	7
DIAGNOSIS-TYPE	CRX00004	CLAIM-DX-RX	X(1)	8
N/A	CRX00004	CLAIM-DX-RX	9(2)	9
DIAGNOSIS-CODE-FLAG	CRX00004	CLAIM-DX-RX	X(1)	10

DIAGNOSIS-CODE	CRX00004	CLAIM-DX-RX	X(7)	11
N/A	CRX00004	CLAIM-DX-RX	X(500)	12
RECORD-ID	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(8)	1
DATA-DICTIONARY-VERSION	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(10)	2
SUBMISSION-TRANSACTION-TYPE	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(1)	3
FILE-ENCODING-SPECIFICATION	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(3)	4
N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(9)	5
N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(8)	6
STATE	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(2)	7
N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	9(8)	8

N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	9(8)	9
N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	9(8)	10
FILE-STATUS-INDICATOR	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(1)	11
SSN-INDICATOR	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(1)	12
N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	9(11)	13
FILE-SUBMISSION-METHOD	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(2)	14
N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(4)	15
N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(500)	16
RECORD-ID	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(8)	1

STATE	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(2)	2
N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	9(11)	3
N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(20)	4
N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(30)	5
N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(30)	6
N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(1)	7
SEX	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(1)	8

N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	9(8)	9
N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	9(8)	10
N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	9(8)	11
N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	9(8)	12

N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(500)	13
RECORD-ID	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(8)	1
STATE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(2)	2
N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(11)	3
N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(20)	4

MARITAL-STATUS	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(2)	5
N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(50)	6
N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(9)	7
SSN-VERIFICATION-FLAG	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	8

INCOME-CODE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(2)	9
VETERAN-IND	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	10
CITIZENSHIP-IND	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	11
CITIZENSHIP-VERIFICATION-FLAG	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	12
IMMIGRATION-STATUS	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	13
IMMIGRATION-VERIFICATION-FLAG	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	14

N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(8)	15
ENGL-PROF-CODE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	16
PREFERRED-LANGUAGE-CODE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(3)	17
HOUSEHOLD-SIZE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(2)	18
PREGNANCY-IND	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	19
N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(12)	20

N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(12)	21
CHIP-CODE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	22
N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(8)	23
N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(8)	24

N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(3)	25
N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(8)	26
N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(500)	27
RECORD-ID	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(8)	1
STATE	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(2)	2
N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	9(11)	3

N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(20)	4
ELIGIBLE-ADDR-TYPE	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(2)	5
N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(60)	6
N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(60)	7
N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(60)	8
N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(28)	9
STATE	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(2)	10
ZIP-CODE	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(9)	11

COUNTY	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(3)	12
N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(10)	13
N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(100)	14
N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	9(8)	15
N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	9(8)	16
N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(500)	17
RECORD-ID	ELG00005	ELIGIBILITY-DETERMINANTS	X(8)	1
STATE	ELG00005	ELIGIBILITY-DETERMINANTS	X(2)	2
N/A	ELG00005	ELIGIBILITY-DETERMINANTS	9(11)	3

N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(20)	4
N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(12)	5
DUAL-ELIGIBLE-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(2)	6

PRIMARY-ELIGIBILITY-GROUP-IND	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	7
ELIGIBILITY-GROUP	ELG00005	ELIGIBILITY-DETERMINANTS	X(2)	8
LEVEL-OF-CARE-STATUS	ELG00005	ELIGIBILITY-DETERMINANTS	X(3)	9
SSDI-IND	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	10

SSI-IND	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	11
SSI-STATE-SUPPLEMENT-STATUS-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(3)	12
SSI-STATUS	ELG00005	ELIGIBILITY-DETERMINANTS	X(3)	13
N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(6)	14
CONCEPTION-TO-BIRTH-IND	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	15

ELIGIBILITY-TERMINATION-REASON	ELG00005	ELIGIBILITY-DETERMINANTS	X(2)	16
RESTRICTED-BENEFITS-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	17

TANF-CASH-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	18
N/A	ELG00005	ELIGIBILITY-DETERMINANTS	9(8)	19
N/A	ELG00005	ELIGIBILITY-DETERMINANTS	9(8)	20
N/A	ELG00005	ELIGIBILITY-DETERMINANTS	9(8)	21
ELIGIBILITY-EXTENSION-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(3)	22
N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(50)	23
CONTINUOUS-ELIGIBILITY-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(3)	24
N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(50)	25
INCOME-STANDARD-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(2)	26
N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(50)	27
N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(100)	28

N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(500)	29
RECORD-ID	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(8)	1
STATE	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(2)	2
N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	9(11)	3
N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(20)	4
N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(100)	5
N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(100)	6
N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	9(8)	7

N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	9(8)	8
N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	9(8)	9
N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(500)	10
RECORD-ID	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(8)	1
STATE	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(2)	2
N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	9(11)	3
N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(20)	4
N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(100)	5
N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(100)	6

N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(30)	7
N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	9(8)	8
N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	9(8)	9
N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	9(8)	10
N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(500)	11
RECORD-ID	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(8)	1
STATE	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(2)	2
N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	9(11)	3

N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(20)	4
HEALTH-HOME-CHRONIC-CONDITION	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(1)	5
N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(50)	6
N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	9(8)	7
N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	9(8)	8
N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(500)	9
RECORD-ID	ELG00009	LOCK-IN-INFORMATION	X(8)	1

STATE	ELG00009	LOCK-IN-INFORMATION	X(2)	2
N/A	ELG00009	LOCK-IN-INFORMATION	9(11)	3
N/A	ELG00009	LOCK-IN-INFORMATION	X(20)	4
N/A	ELG00009	LOCK-IN-INFORMATION	X(30)	5
PROV-TYPE	ELG00009	LOCK-IN-INFORMATION	X(2)	6
N/A	ELG00009	LOCK-IN-INFORMATION	9(8)	7
N/A	ELG00009	LOCK-IN-INFORMATION	9(8)	8
TYPE-OF-SERVICE	ELG00009	LOCK-IN-INFORMATION	X(3)	9
N/A	ELG00009	LOCK-IN-INFORMATION	X(500)	10

RECORD-ID	ELG00010	MFP-INFORMATION	X(8)	1
STATE	ELG00010	MFP-INFORMATION	X(2)	2
N/A	ELG00010	MFP-INFORMATION	9(11)	3
N/A	ELG00010	MFP-INFORMATION	X(20)	4
MFP-LIVES-WITH-FAMILY	ELG00010	MFP-INFORMATION	X(1)	5
MFP-QUALIFIED-INSTITUTION	ELG00010	MFP-INFORMATION	X(2)	6
MFP-QUALIFIED-RESIDENCE	ELG00010	MFP-INFORMATION	X(2)	7
MFP-REASON-PARTICIPATION-ENDED	ELG00010	MFP-INFORMATION	X(2)	8

MFP-REINSTITUTIONALIZED-REASON	ELG00010	MFP-INFORMATION	X(2)	9
N/A	ELG00010	MFP-INFORMATION	9(8)	10
N/A	ELG00010	MFP-INFORMATION	9(8)	11
N/A	ELG00010	MFP-INFORMATION	X(500)	12
RECORD-ID	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	X(8)	1
STATE	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	X(2)	2
N/A	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	9(11)	3
N/A	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	X(20)	4

STATE-PLAN-OPTION-TYPE	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	X(2)	5
N/A	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	9(8)	6
N/A	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	9(8)	7
N/A	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	X(500)	8
RECORD-ID	ELG00012	WAIVER-PARTICIPATION	X(8)	1
STATE	ELG00012	WAIVER-PARTICIPATION	X(2)	2
N/A	ELG00012	WAIVER-PARTICIPATION	9(11)	3

N/A	ELG00012	WAIVER-PARTICIPATION	X(20)	4
N/A	ELG00012	WAIVER-PARTICIPATION	X(20)	5
WAIVER-TYPE	ELG00012	WAIVER-PARTICIPATION	X(2)	6
N/A	ELG00012	WAIVER-PARTICIPATION	9(8)	7
N/A	ELG00012	WAIVER-PARTICIPATION	9(8)	8
N/A	ELG00012	WAIVER-PARTICIPATION	X(500)	9

RECORD-ID	ELG00013	LTSS-PARTICIPATION	X(8)	1
STATE	ELG00013	LTSS-PARTICIPATION	X(2)	2
N/A	ELG00013	LTSS-PARTICIPATION	9(11)	3
N/A	ELG00013	LTSS-PARTICIPATION	X(20)	4
LTSS-LEVEL-CARE	ELG00013	LTSS-PARTICIPATION	X(1)	5
N/A	ELG00013	LTSS-PARTICIPATION	X(30)	6
N/A	ELG00013	LTSS-PARTICIPATION	9(8)	7
N/A	ELG00013	LTSS-PARTICIPATION	9(8)	8
N/A	ELG00013	LTSS-PARTICIPATION	X(500)	9

RECORD-ID	ELG00014	MANAGED-CARE-PARTICIPATION	X(8)	1
STATE	ELG00014	MANAGED-CARE-PARTICIPATION	X(2)	2
N/A	ELG00014	MANAGED-CARE-PARTICIPATION	9(11)	3
N/A	ELG00014	MANAGED-CARE-PARTICIPATION	X(20)	4
N/A	ELG00014	MANAGED-CARE-PARTICIPATION	X(12)	5

MANAGED-CARE-PLAN-TYPE	ELG00014	MANAGED-CARE-PARTICIPATION	X(2)	6
N/A	ELG00014	MANAGED-CARE-PARTICIPATION	9(8)	7
N/A	ELG00014	MANAGED-CARE-PARTICIPATION	9(8)	8
N/A	ELG00014	MANAGED-CARE-PARTICIPATION	X(500)	9
RECORD-ID	ELG00015	ETHNICITY-INFORMATION	X(8)	1
STATE	ELG00015	ETHNICITY-INFORMATION	X(2)	2
N/A	ELG00015	ETHNICITY-INFORMATION	9(11)	3

N/A	ELG00015	ETHNICITY-INFORMATION	X(20)	4
ETHNICITY-CODE	ELG00015	ETHNICITY-INFORMATION	X(1)	5
N/A	ELG00015	ETHNICITY-INFORMATION	9(8)	6
N/A	ELG00015	ETHNICITY-INFORMATION	9(8)	7
N/A	ELG00015	ETHNICITY-INFORMATION	X(25)	8
N/A	ELG00015	ETHNICITY-INFORMATION	X(500)	9

RECORD-ID	ELG00016	RACE-INFORMATION	X(8)	1
STATE	ELG00016	RACE-INFORMATION	X(2)	2
N/A	ELG00016	RACE-INFORMATION	9(11)	3
N/A	ELG00016	RACE-INFORMATION	X(20)	4

RACE	ELG00016	RACE-INFORMATION	X(3)	5
N/A	ELG00016	RACE-INFORMATION	X(25)	6

AMERICAN-INDIAN-ALASKA-NATIVE-INDICATOR	ELG00016	RACE-INFORMATION	X(1)	7
N/A	ELG00016	RACE-INFORMATION	9(8)	8
N/A	ELG00016	RACE-INFORMATION	9(8)	9
N/A	ELG00016	RACE-INFORMATION	X(500)	10
RECORD-ID	ELG00017	DISABILITY-INFORMATION	X(8)	1

STATE	ELG00017	DISABILITY-INFORMATION	X(2)	2
N/A	ELG00017	DISABILITY-INFORMATION	9(11)	3
N/A	ELG00017	DISABILITY-INFORMATION	X(20)	4
DISABILITY-TYPE-CODE	ELG00017	DISABILITY-INFORMATION	X(2)	5
N/A	ELG00017	DISABILITY-INFORMATION	9(8)	6
N/A	ELG00017	DISABILITY-INFORMATION	9(8)	7
N/A	ELG00017	DISABILITY-INFORMATION	X(500)	8
RECORD-ID	ELG00018	1115A-DEMONSTRATION-INFORMATION	X(8)	1

STATE	ELG00018	1115A-DEMONSTRATION-INFORMATION	X(2)	2
N/A	ELG00018	1115A-DEMONSTRATION-INFORMATION	9(11)	3
N/A	ELG00018	1115A-DEMONSTRATION-INFORMATION	X(20)	4
1115A-DEMONSTRATION-IND	ELG00018	1115A-DEMONSTRATION-INFORMATION	X(1)	5
N/A	ELG00018	1115A-DEMONSTRATION-INFORMATION	9(8)	6
N/A	ELG00018	1115A-DEMONSTRATION-INFORMATION	9(8)	7
N/A	ELG00018	1115A-DEMONSTRATION-INFORMATION	X(500)	8
RECORD-ID	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	X(8)	1

STATE	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	X(2)	2
N/A	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	9(11)	3
N/A	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	X(20)	4
HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-CODE	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	X(3)	5
N/A	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	9(8)	6
N/A	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	9(8)	7
N/A	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	X(500)	8
RECORD-ID	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	X(8)	1

STATE	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	X(2)	2
N/A	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	9(11)	3
N/A	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	X(20)	4
ENROLLMENT-TYPE	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	X(1)	5
N/A	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	9(8)	6
N/A	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	9(8)	7
N/A	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	X(500)	8

RECORD-ID	ELG00022	ELG-IDENTIFIERS	X(8)	1
STATE	ELG00022	ELG-IDENTIFIERS	X(2)	2
N/A	ELG00022	ELG-IDENTIFIERS	9(11)	3
N/A	ELG00022	ELG-IDENTIFIERS	X(20)	4
ELG-IDENTIFIER-TYPE	ELG00022	ELG-IDENTIFIERS	X(1)	5
N/A	ELG00022	ELG-IDENTIFIERS	X(18)	6
N/A	ELG00022	ELG-IDENTIFIERS	9(8)	7
N/A	ELG00022	ELG-IDENTIFIERS	9(8)	8

N/A	ELG00022	ELG-IDENTIFIERS	X(20)	9
REASON-FOR-CHANGE	ELG00022	ELG-IDENTIFIERS	X(10)	10
N/A	ELG00022	ELG-IDENTIFIERS	X(500)	11
RECORD-ID	ELG00023	SOGI	X(8)	1

STATE	ELG00023	SOGI	X(2)	2
N/A	ELG00023	SOGI	9(11)	3
N/A	ELG00023	SOGI	X(20)	4
SEX-ASSIGNED-AT-BIRTH	ELG00023	SOGI	X(1)	5
N/A	ELG00023	SOGI	X(100)	6

GENDER-IDENTITY	ELG00023	SOGI	X(1)	7
N/A	ELG00023	SOGI	X(100)	8
SEXUAL-ORIENTATION	ELG00023	SOGI	X(1)	9
N/A	ELG00023	SOGI	X(100)	10
N/A	ELG00023	SOGI	9(8)	11
N/A	ELG00023	SOGI	9(8)	12
N/A	ELG00023	SOGI	X(500)	13

RECORD-ID	FTX00001	FILE-HEADER-RECORD-FTX	X(8)	1
DATA-DICTIONARY-VERSION	FTX00001	FILE-HEADER-RECORD-FTX	X(10)	2
SUBMISSION-TRANSACTION-TYPE	FTX00001	FILE-HEADER-RECORD-FTX	X(1)	3
FILE-ENCODING-SPECIFICATION	FTX00001	FILE-HEADER-RECORD-FTX	X(3)	4
N/A	FTX00001	FILE-HEADER-RECORD-FTX	X(9)	5
N/A	FTX00001	FILE-HEADER-RECORD-FTX	X(8)	6
STATE	FTX00001	FILE-HEADER-RECORD-FTX	X(2)	7
N/A	FTX00001	FILE-HEADER-RECORD-FTX	9(8)	8
N/A	FTX00001	FILE-HEADER-RECORD-FTX	9(8)	9
N/A	FTX00001	FILE-HEADER-RECORD-FTX	9(8)	10

FILE-STATUS-INDICATOR	FTX00001	FILE-HEADER-RECORD-FTX	X(1)	11
SSN-INDICATOR	FTX00001	FILE-HEADER-RECORD-FTX	X(1)	12
N/A	FTX00001	FILE-HEADER-RECORD-FTX	9(11)	13
N/A	FTX00001	FILE-HEADER-RECORD-FTX	X(4)	14
N/A	FTX00001	FILE-HEADER-RECORD-FTX	X(500)	15
RECORD-ID	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(8)	1
STATE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	2
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	9(11)	3
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(50)	4

N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(50)	5
ADJUSTMENT-IND	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(1)	6
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	9(8)	7
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	S9(11)V99	8
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	9(8)	9
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(15)	10
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(30)	11
PAYER-ID-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	12

N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	13
MANAGED-CARE-PLAN-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	14
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	15
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(30)	16
PAYEE-ID-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	17
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	18
MANAGED-CARE-PLAN-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	19

N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	20
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(30)	21
PAYEE-TAX-ID-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	22
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	23
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	24
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(20)	25
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	9(8)	26
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	9(8)	27

CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	28
MBESCBES-FORM-GROUP	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(1)	29
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(50)	30
21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(5)	31

N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(20)	32
WAIVER-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	33
FUNDING-CODE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	34
FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	35
SDP-IND	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(1)	36
SOURCE-LOCATION	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	37
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(15)	38

SUBCAPITATION-IND	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(1)	39
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(50)	40
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	41
EXPENDITURE-AUTHORITY-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	42
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	43
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(500)	44
N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(500)	45
RECORD-ID	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(8)	1
STATE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	2

N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	9(11)	3
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(50)	4
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(50)	5
ADJUSTMENT-IND	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(1)	6
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	9(8)	7
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	S9(11)V99	8
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	9(8)	9
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(15)	10
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(30)	11

PAYER-ID-TYPE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	12
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(100)	13
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(30)	14
PAYEE-ID-TYPE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	15
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(100)	16
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(30)	17

PAYEE-TAX-ID-TYPE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	18
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(100)	19
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(12)	20
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(20)	21
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(20)	22
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(20)	23
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	9(8)	24
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	9(8)	25
CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	26
MBESCBES-FORM-GROUP	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(1)	27

MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(50)	28
21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(5)	29
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(20)	30
WAIVER-TYPE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	31

FUNDING-CODE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	32
FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	33
SOURCE-LOCATION	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	34
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(15)	35
EXPENDITURE-AUTHORITY-TYPE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	36
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(100)	37
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(500)	38
N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(500)	39

RECORD-ID	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(8)	1
STATE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	2
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	9(11)	3
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(50)	4
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(50)	5
ADJUSTMENT-IND	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(1)	6
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	9(8)	7
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	S9(11)V99	8
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	9(8)	9
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(15)	10

N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(30)	11
PAYER-ID-TYPE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	12
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(100)	13
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(30)	14
PAYEE-ID-TYPE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	15
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(100)	16

N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(30)	17
PAYEE-TAX-ID-TYPE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	18
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(100)	19
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(12)	20
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(20)	21
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(20)	22

N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(9)	23
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(20)	24
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(16)	25
POLICY-OWNER-CODE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	26
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	9(8)	27
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	9(8)	28
CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	29
MBESCBES-FORM-GROUP	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(1)	30
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(50)	31

21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(5)	32
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(20)	33
WAIVER-TYPE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	34
FUNDING-CODE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	35

FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	36
SOURCE-LOCATION	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	37
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(15)	38
EXPENDITURE-AUTHORITY-TYPE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	39
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(100)	40
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(500)	41
N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(500)	42
RECORD-ID	FTX00005	COST-SHARING-OFFSET	X(8)	1

STATE	FTX00005	COST-SHARING-OFFSET	X(2)	2
N/A	FTX00005	COST-SHARING-OFFSET	9(11)	3
N/A	FTX00005	COST-SHARING-OFFSET	X(50)	4
N/A	FTX00005	COST-SHARING-OFFSET	X(50)	5
ADJUSTMENT-IND	FTX00005	COST-SHARING-OFFSET	X(1)	6
N/A	FTX00005	COST-SHARING-OFFSET	9(8)	7
N/A	FTX00005	COST-SHARING-OFFSET	S9(11)V99	8
N/A	FTX00005	COST-SHARING-OFFSET	9(8)	9
N/A	FTX00005	COST-SHARING-OFFSET	X(15)	10
N/A	FTX00005	COST-SHARING-OFFSET	X(30)	11

PAYER-ID-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	12
N/A	FTX00005	COST-SHARING-OFFSET	X(100)	13
N/A	FTX00005	COST-SHARING-OFFSET	X(30)	14
PAYEE-ID-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	15
N/A	FTX00005	COST-SHARING-OFFSET	X(100)	16
MANAGED-CARE-PLAN-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	17
N/A	FTX00005	COST-SHARING-OFFSET	X(100)	18

N/A	FTX00005	COST-SHARING-OFFSET	X(30)	19
PAYEE-TAX-ID-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	20
N/A	FTX00005	COST-SHARING-OFFSET	X(100)	21
N/A	FTX00005	COST-SHARING-OFFSET	X(100)	22
N/A	FTX00005	COST-SHARING-OFFSET	X(20)	23
N/A	FTX00005	COST-SHARING-OFFSET	X(20)	24
N/A	FTX00005	COST-SHARING-OFFSET	9(8)	25

N/A	FTX00005	COST-SHARING-OFFSET	9(8)	26
CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00005	COST-SHARING-OFFSET	X(2)	27
MBESCBES-FORM-GROUP	FTX00005	COST-SHARING-OFFSET	X(1)	28
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00005	COST-SHARING-OFFSET	X(50)	29
21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00005	COST-SHARING-OFFSET	X(5)	30

N/A	FTX00005	COST-SHARING-OFFSET	X(20)	31
WAIVER-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	32
FUNDING-CODE	FTX00005	COST-SHARING-OFFSET	X(2)	33
FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00005	COST-SHARING-OFFSET	X(2)	34
OFFSET-TRANS-TYPE	FTX00005	COST-SHARING-OFFSET	X(1)	35
SOURCE-LOCATION	FTX00005	COST-SHARING-OFFSET	X(2)	36
N/A	FTX00005	COST-SHARING-OFFSET	X(15)	37

EXPENDITURE-AUTHORITY-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	38
N/A	FTX00005	COST-SHARING-OFFSET	X(100)	39
N/A	FTX00005	COST-SHARING-OFFSET	X(500)	40
N/A	FTX00005	COST-SHARING-OFFSET	X(500)	41
RECORD-ID	FTX00006	VALUE-BASED-PAYMENT	X(8)	1
STATE	FTX00006	VALUE-BASED-PAYMENT	X(2)	2
N/A	FTX00006	VALUE-BASED-PAYMENT	9(11)	3
N/A	FTX00006	VALUE-BASED-PAYMENT	X(50)	4
N/A	FTX00006	VALUE-BASED-PAYMENT	X(50)	5
ADJUSTMENT-IND	FTX00006	VALUE-BASED-PAYMENT	X(1)	6

N/A	FTX00006	VALUE-BASED-PAYMENT	9(8)	7
N/A	FTX00006	VALUE-BASED-PAYMENT	S9(11)V99	8
N/A	FTX00006	VALUE-BASED-PAYMENT	9(8)	9
N/A	FTX00006	VALUE-BASED-PAYMENT	X(15)	10
N/A	FTX00006	VALUE-BASED-PAYMENT	X(30)	11
PAYER-ID-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	12
N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	13
N/A	FTX00006	VALUE-BASED-PAYMENT	X(30)	14

PAYEE-ID-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	15
N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	16
MANAGED-CARE-PLAN-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	17
N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	18
N/A	FTX00006	VALUE-BASED-PAYMENT	X(30)	19
PAYEE-TAX-ID-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	20
N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	21
N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	22

N/A	FTX00006	VALUE-BASED-PAYMENT	X(20)	23
N/A	FTX00006	VALUE-BASED-PAYMENT	9(8)	24
N/A	FTX00006	VALUE-BASED-PAYMENT	9(8)	25
CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00006	VALUE-BASED-PAYMENT	X(2)	26
MBESCBES-FORM-GROUP	FTX00006	VALUE-BASED-PAYMENT	X(1)	27
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00006	VALUE-BASED-PAYMENT	X(50)	28

21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00006	VALUE-BASED-PAYMENT	X(5)	29
N/A	FTX00006	VALUE-BASED-PAYMENT	X(20)	30
WAIVER-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	31
FUNDING-CODE	FTX00006	VALUE-BASED-PAYMENT	X(2)	32
FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00006	VALUE-BASED-PAYMENT	X(2)	33
SDP-IND	FTX00006	VALUE-BASED-PAYMENT	X(1)	34

SOURCE-LOCATION	FTX00006	VALUE-BASED-PAYMENT	X(2)	35
N/A	FTX00006	VALUE-BASED-PAYMENT	X(15)	36
VALUE-BASED-PAYMENT-MODEL-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	37
N/A	FTX00006	VALUE-BASED-PAYMENT	X(50)	38
EXPENDITURE-AUTHORITY-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	39
N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	40
N/A	FTX00006	VALUE-BASED-PAYMENT	X(500)	41
N/A	FTX00006	VALUE-BASED-PAYMENT	X(500)	42

RECORD-ID	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(8)	1
STATE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	2
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	9(11)	3
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(50)	4
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(50)	5
ADJUSTMENT-IND	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(1)	6
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	9(8)	7
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	S9(11)V99	8
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	9(8)	9
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(15)	10

N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(30)	11
PAYER-ID-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	12
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	13
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(30)	14
PAYEE-ID-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	15

N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	16
MANAGED-CARE-PLAN-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	17
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	18
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(30)	19
PAYEE-TAX-ID-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	20
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	21
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	22
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	9(8)	23
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	9(8)	24
PAYMENT-PERIOD-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	25
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	26

CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	27
MBESCBES-FORM-GROUP	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(1)	28
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(50)	29
21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(5)	30
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(20)	31

WAIVER-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	32
FUNDING-CODE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	33
FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	34
SOURCE-LOCATION	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	35
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(15)	36
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(50)	37
EXPENDITURE-AUTHORITY-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	38
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	39
N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(500)	40

N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(500)	41
RECORD-ID	FTX00008	COST-SETTLEMENT-PAYMENT	X(8)	1
STATE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	2
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	9(11)	3
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(50)	4
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(50)	5
ADJUSTMENT-IND	FTX00008	COST-SETTLEMENT-PAYMENT	X(1)	6
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	9(8)	7
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	S9(11)V99	8
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	9(8)	9

N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(15)	10
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(30)	11
PAYER-ID-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	12
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(100)	13
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(30)	14

PAYEE-ID-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	15
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(100)	16
MANAGED-CARE-PLAN-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	17
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(100)	18
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(30)	19
PAYEE-TAX-ID-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	20
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(100)	21
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	9(8)	22

N/A	FTX00008	COST-SETTLEMENT-PAYMENT	9(8)	23
CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	24
MBESCBES-FORM-GROUP	FTX00008	COST-SETTLEMENT-PAYMENT	X(1)	25
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00008	COST-SETTLEMENT-PAYMENT	X(50)	26
21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00008	COST-SETTLEMENT-PAYMENT	X(5)	27

N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(20)	28
WAIVER-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	29
FUNDING-CODE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	30
FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	31
SOURCE-LOCATION	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	32
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(15)	33
EXPENDITURE-AUTHORITY-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	34

N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(100)	35
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(500)	36
N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(500)	37
RECORD-ID	FTX00009	FQHC-WRAP-PAYMENT	X(8)	1
STATE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	2
N/A	FTX00009	FQHC-WRAP-PAYMENT	9(11)	3
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(50)	4
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(50)	5
ADJUSTMENT-IND	FTX00009	FQHC-WRAP-PAYMENT	X(1)	6
N/A	FTX00009	FQHC-WRAP-PAYMENT	9(8)	7
N/A	FTX00009	FQHC-WRAP-PAYMENT	S9(11)V99	8

N/A	FTX00009	FQHC-WRAP-PAYMENT	9(8)	9
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(15)	10
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(30)	11
PAYER-ID-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	12
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(100)	13
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(30)	14

PAYEE-ID-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	15
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(100)	16
MANAGED-CARE-PLAN-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	17
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(100)	18
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(30)	19
PAYEE-TAX-ID-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	20
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(100)	21
N/A	FTX00009	FQHC-WRAP-PAYMENT	9(8)	22

N/A	FTX00009	FQHC-WRAP-PAYMENT	9(8)	23
CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00009	FQHC-WRAP-PAYMENT	X(2)	24
MBESCBES-FORM-GROUP	FTX00009	FQHC-WRAP-PAYMENT	X(1)	25
MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00009	FQHC-WRAP-PAYMENT	X(50)	26
21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00009	FQHC-WRAP-PAYMENT	X(5)	27

N/A	FTX00009	FQHC-WRAP-PAYMENT	X(20)	28
WAIVER-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	29
FUNDING-CODE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	30
FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	31
SOURCE-LOCATION	FTX00009	FQHC-WRAP-PAYMENT	X(2)	32
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(15)	33
EXPENDITURE-AUTHORITY-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	34

N/A	FTX00009	FQHC-WRAP-PAYMENT	X(100)	35
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(500)	36
N/A	FTX00009	FQHC-WRAP-PAYMENT	X(500)	37
RECORD-ID	FTX00095	MISCELLANEOUS-PAYMENT	X(8)	1
STATE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	2
N/A	FTX00095	MISCELLANEOUS-PAYMENT	9(11)	3
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(50)	4
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(50)	5
ADJUSTMENT-IND	FTX00095	MISCELLANEOUS-PAYMENT	X(1)	6
N/A	FTX00095	MISCELLANEOUS-PAYMENT	9(8)	7
N/A	FTX00095	MISCELLANEOUS-PAYMENT	S9(11)V99	8

N/A	FTX00095	MISCELLANEOUS-PAYMENT	9(8)	9
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(15)	10
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(30)	11
PAYER-ID-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	12
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	13
MANAGED-CARE-PLAN-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	14
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	15
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(30)	16

PAYEE-ID-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	17
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	18
MANAGED-CARE-PLAN-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	19
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	20
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(30)	21
PAYEE-TAX-ID-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	22
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	23
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	24
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(12)	25

N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(20)	26
N/A	FTX00095	MISCELLANEOUS-PAYMENT	9(8)	27
N/A	FTX00095	MISCELLANEOUS-PAYMENT	9(8)	28
PAYMENT-PERIOD-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	29
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	30
TRANSACTION-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	31
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	32
CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	33
MBESCBES-FORM-GROUP	FTX00095	MISCELLANEOUS-PAYMENT	X(1)	34

MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00095	MISCELLANEOUS-PAYMENT	X(50)	35
21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00095	MISCELLANEOUS-PAYMENT	X(5)	36
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(20)	37
WAIVER-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	38
FUNDING-CODE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	39

FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	40
SDP-IND	FTX00095	MISCELLANEOUS-PAYMENT	X(1)	41
SOURCE-LOCATION	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	42
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(15)	43
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(50)	44
EXPENDITURE-AUTHORITY-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	45
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	46
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(500)	47
N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(500)	48

RECORD-ID	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(8)	1
DATA-DICTIONARY-VERSION	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(10)	2
SUBMISSION-TRANSACTION-TYPE	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(1)	3
FILE-ENCODING-SPECIFICATION	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(3)	4
N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(9)	5
N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(8)	6
STATE	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(2)	7
N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	9(8)	8
N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	9(8)	9
N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	9(8)	10

FILE-STATUS-INDICATOR	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(1)	11
N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	9(11)	12
FILE-SUBMISSION-METHOD	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(2)	13
N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(4)	14
N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(500)	15
RECORD-ID	MCR00002	MANAGED-CARE-MAIN	X(8)	1
STATE	MCR00002	MANAGED-CARE-MAIN	X(2)	2
N/A	MCR00002	MANAGED-CARE-MAIN	9(11)	3
N/A	MCR00002	MANAGED-CARE-MAIN	X(12)	4
N/A	MCR00002	MANAGED-CARE-MAIN	9(8)	5

N/A	MCR00002	MANAGED-CARE-MAIN	9(8)	6
N/A	MCR00002	MANAGED-CARE-MAIN	X(55)	7
MANAGED-CARE-PROGRAM	MCR00002	MANAGED-CARE-MAIN	X(1)	8
MANAGED-CARE-PLAN-TYPE	MCR00002	MANAGED-CARE-MAIN	X(2)	9
REIMBURSEMENT-ARRANGEMENT	MCR00002	MANAGED-CARE-MAIN	X(2)	10
MANAGED-CARE-PROFIT-STATUS	MCR00002	MANAGED-CARE-MAIN	X(2)	11

CORE-BASED-STATISTICAL-AREA-CODE	MCR00002	MANAGED-CARE-MAIN	X(1)	12
N/A	MCR00002	MANAGED-CARE-MAIN	9(3)	13
MANAGED-CARE-SERVICE-AREA	MCR00002	MANAGED-CARE-MAIN	X(1)	14
N/A	MCR00002	MANAGED-CARE-MAIN	9(8)	15

N/A	MCR00002	MANAGED-CARE-MAIN	9(8)	16
N/A	MCR00002	MANAGED-CARE-MAIN	X(500)	17
RECORD-ID	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(8)	1
STATE	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(2)	2
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	9(11)	3
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(12)	4
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(15)	5
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	9(8)	6
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	9(8)	7
MANAGED-CARE-ADDR-TYPE	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(1)	8

N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(60)	9
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(60)	10
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(60)	11
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(28)	12
STATE	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(2)	13
ZIP-CODE	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(9)	14
COUNTY	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(3)	15
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(10)	16
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(60)	17
N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(10)	18

N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(500)	19
RECORD-ID	MCR00004	MANAGED-CARE-SERVICE-AREA	X(8)	1
STATE	MCR00004	MANAGED-CARE-SERVICE-AREA	X(2)	2
N/A	MCR00004	MANAGED-CARE-SERVICE-AREA	9(11)	3
N/A	MCR00004	MANAGED-CARE-SERVICE-AREA	X(12)	4
MANAGED-CARE-SERVICE-AREA-NAME	MCR00004	MANAGED-CARE-SERVICE-AREA	X(30)	5
N/A	MCR00004	MANAGED-CARE-SERVICE-AREA	9(8)	6

N/A	MCR00004	MANAGED-CARE-SERVICE-AREA	9(8)	7
N/A	MCR00004	MANAGED-CARE-SERVICE-AREA	X(500)	8
RECORD-ID	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(8)	1
STATE	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(2)	2
N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	9(11)	3
N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(12)	4
OPERATING-AUTHORITY	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(2)	5
N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(20)	6
N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	9(8)	7

N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	9(8)	8
N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(500)	9
RECORD-ID	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	X(8)	1
STATE	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	X(2)	2
N/A	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	9(11)	3
N/A	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	X(12)	4
ELIGIBILITY-GROUP	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	9(2)	5
N/A	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	9(8)	6
N/A	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	9(8)	7
N/A	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	X(500)	8

RECORD-ID	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	X(8)	1
STATE	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	X(2)	2
N/A	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	9(11)	3
N/A	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	X(12)	4
ACCREDITATION-ORGANIZATION	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	X(2)	5
N/A	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	9(8)	6
N/A	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	9(8)	7
N/A	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	X(500)	8
RECORD-ID	MCR00010	MANAGED-CARE-ID	X(8)	1
STATE	MCR00010	MANAGED-CARE-ID	X(2)	2

N/A	MCR00010	MANAGED-CARE-ID	9(11)	3
N/A	MCR00010	MANAGED-CARE-ID	X(12)	4
MANAGED-CARE-PLAN-OTHER-ID-TYPE	MCR00010	MANAGED-CARE-ID	X(2)	5
N/A	MCR00010	MANAGED-CARE-ID	X(30)	6
N/A	MCR00010	MANAGED-CARE-ID	9(8)	7
N/A	MCR00010	MANAGED-CARE-ID	9(8)	8
N/A	MCR00010	MANAGED-CARE-ID	X(500)	9
RECORD-ID	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(8)	1
DATA-DICTIONARY-VERSION	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(10)	2
SUBMISSION-TRANSACTION-TYPE	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(1)	3
FILE-ENCODING-SPECIFICATION	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(3)	4
N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(9)	5

N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(8)	6
STATE	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(2)	7
N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	9(8)	8
N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	9(8)	9
N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	9(8)	10
FILE-STATUS-INDICATOR	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(1)	11
N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	9(11)	12
FILE-SUBMISSION-METHOD	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(2)	13
N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(4)	14

N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(500)	15
RECORD-ID	PRV00002	PROV-ATTRIBUTES-MAIN	X(8)	1
STATE	PRV00002	PROV-ATTRIBUTES-MAIN	X(2)	2
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	9(11)	3
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(30)	4
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	9(8)	5
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	9(8)	6
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(100)	7
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(100)	8
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(60)	9

N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(100)	10
FACILITY-GROUP-INDIVIDUAL-CODE	PRV00002	PROV-ATTRIBUTES-MAIN	X(2)	11
TEACHING-IND	PRV00002	PROV-ATTRIBUTES-MAIN	X(1)	12
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(30)	13
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(1)	14
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(30)	15
SEX	PRV00002	PROV-ATTRIBUTES-MAIN	X(1)	16
OWNERSHIP-CODE	PRV00002	PROV-ATTRIBUTES-MAIN	X(2)	17

PROV-PROFIT-STATUS	PRV00002	PROV-ATTRIBUTES-MAIN	X(2)	18
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	9(8)	19
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	9(8)	20
ACCEPTING-NEW-PATIENTS-IND	PRV00002	PROV-ATTRIBUTES-MAIN	X(1)	21
ATYPICAL-PROV-IND	PRV00002	PROV-ATTRIBUTES-MAIN	X(1)	22
N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(500)	23
RECORD-ID	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(8)	1
STATE	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(2)	2
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	9(11)	3
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(30)	4

N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(5)	5
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	9(8)	6
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	9(8)	7
PROV-ADDR-TYPE	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(1)	8
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(60)	9
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(60)	10
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(60)	11
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(28)	12

STATE	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(2)	13
ZIP-CODE	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(9)	14
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(10)	15
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(60)	16
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(10)	17
ADDR-BORDER-STATE-IND	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(1)	18
COUNTY	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(3)	19
N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(500)	20
RECORD-ID	PRV00004	PROV-LICENSING-INFO	X(8)	1
STATE	PRV00004	PROV-LICENSING-INFO	X(2)	2
N/A	PRV00004	PROV-LICENSING-INFO	9(11)	3

N/A	PRV00004	PROV-LICENSING-INFO	X(30)	4
N/A	PRV00004	PROV-LICENSING-INFO	X(5)	5
N/A	PRV00004	PROV-LICENSING-INFO	9(8)	6
N/A	PRV00004	PROV-LICENSING-INFO	9(8)	7
LICENSE-TYPE	PRV00004	PROV-LICENSING-INFO	X(1)	8
N/A	PRV00004	PROV-LICENSING-INFO	X(60)	9

N/A	PRV00004	PROV-LICENSING-INFO	X(20)	10
N/A	PRV00004	PROV-LICENSING-INFO	X(500)	11
RECORD-ID	PRV00005	PROV-IDENTIFIERS	X(8)	1
STATE	PRV00005	PROV-IDENTIFIERS	X(2)	2
N/A	PRV00005	PROV-IDENTIFIERS	9(11)	3
N/A	PRV00005	PROV-IDENTIFIERS	X(30)	4
N/A	PRV00005	PROV-IDENTIFIERS	X(5)	5
PROV-IDENTIFIER-TYPE	PRV00005	PROV-IDENTIFIERS	X(1)	6

N/A	PRV00005	PROV-IDENTIFIERS	X(18)	7
N/A	PRV00005	PROV-IDENTIFIERS	9(8)	8
N/A	PRV00005	PROV-IDENTIFIERS	9(8)	9
N/A	PRV00005	PROV-IDENTIFIERS	X(30)	10
N/A	PRV00005	PROV-IDENTIFIERS	X(500)	11
RECORD-ID	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(8)	1

STATE	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(2)	2
N/A	PRV00006	PROV-TAXONOMY-CLASSIFICATION	9(11)	3
N/A	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(30)	4
PROV-CLASSIFICATION-TYPE	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(1)	5
PROV-CLASSIFICATION-CODE-TYPE-4, PROV-TAXONOMY, PROV-TYPE, PROV-SPECIALTY	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(20)	6
N/A	PRV00006	PROV-TAXONOMY-CLASSIFICATION	9(8)	7
N/A	PRV00006	PROV-TAXONOMY-CLASSIFICATION	9(8)	8
N/A	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(500)	9

RECORD-ID	PRV00007	PROV-MEDICAID-ENROLLMENT	X(8)	1
STATE	PRV00007	PROV-MEDICAID-ENROLLMENT	X(2)	2
N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	9(11)	3
N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	X(30)	4
N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	9(8)	5
N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	9(8)	6
PROV-MEDICAID-ENROLLMENT-STATUS-CODE	PRV00007	PROV-MEDICAID-ENROLLMENT	X(2)	7
STATE-PLAN-ENROLLMENT	PRV00007	PROV-MEDICAID-ENROLLMENT	X(1)	8
PROV-ENROLLMENT-METHOD	PRV00007	PROV-MEDICAID-ENROLLMENT	X(1)	9
N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	9(8)	10

N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	X(500)	11
RECORD-ID	PRV00008	PROV-AFFILIATED-GROUPS	X(8)	1
STATE	PRV00008	PROV-AFFILIATED-GROUPS	X(2)	2
N/A	PRV00008	PROV-AFFILIATED-GROUPS	9(11)	3
N/A	PRV00008	PROV-AFFILIATED-GROUPS	X(30)	4
N/A	PRV00008	PROV-AFFILIATED-GROUPS	X(30)	5
N/A	PRV00008	PROV-AFFILIATED-GROUPS	9(8)	6
N/A	PRV00008	PROV-AFFILIATED-GROUPS	9(8)	7
N/A	PRV00008	PROV-AFFILIATED-GROUPS	X(500)	8

RECORD-ID	PRV00009	PROV-AFFILIATED-PROGRAMS	X(8)	1
STATE	PRV00009	PROV-AFFILIATED-PROGRAMS	X(2)	2
N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	9(11)	3
N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	X(30)	4
AFFILIATED-PROGRAM-TYPE	PRV00009	PROV-AFFILIATED-PROGRAMS	X(1)	5
N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	X(50)	6
N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	9(8)	7
N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	9(8)	8
N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	X(500)	9

RECORD-ID	PRV00010	PROV-BED-TYPE-INFO	X(8)	1
STATE	PRV00010	PROV-BED-TYPE-INFO	X(2)	2
N/A	PRV00010	PROV-BED-TYPE-INFO	9(11)	3
N/A	PRV00010	PROV-BED-TYPE-INFO	X(30)	4
N/A	PRV00010	PROV-BED-TYPE-INFO	X(5)	5
N/A	PRV00010	PROV-BED-TYPE-INFO	9(8)	6
N/A	PRV00010	PROV-BED-TYPE-INFO	9(8)	7
BED-TYPE-CODE	PRV00010	PROV-BED-TYPE-INFO	X(1)	8

N/A	PRV00010	PROV-BED-TYPE-INFO	9(5)	9
N/A	PRV00010	PROV-BED-TYPE-INFO	X(500)	10
RECORD-ID	TPL00001	FILE-HEADER-RECORD-TPL	X(8)	1
DATA-DICTIONARY-VERSION	TPL00001	FILE-HEADER-RECORD-TPL	X(10)	2
SUBMISSION-TRANSACTION-TYPE	TPL00001	FILE-HEADER-RECORD-TPL	X(1)	3
FILE-ENCODING-SPECIFICATION	TPL00001	FILE-HEADER-RECORD-TPL	X(3)	4
N/A	TPL00001	FILE-HEADER-RECORD-TPL	X(9)	5
N/A	TPL00001	FILE-HEADER-RECORD-TPL	X(8)	6
STATE	TPL00001	FILE-HEADER-RECORD-TPL	X(2)	7
N/A	TPL00001	FILE-HEADER-RECORD-TPL	9(8)	8

N/A	TPL00001	FILE-HEADER-RECORD-TPL	9(8)	9
N/A	TPL00001	FILE-HEADER-RECORD-TPL	9(8)	10
FILE-STATUS-INDICATOR	TPL00001	FILE-HEADER-RECORD-TPL	X(1)	11
SSN-INDICATOR	TPL00001	FILE-HEADER-RECORD-TPL	X(1)	12
N/A	TPL00001	FILE-HEADER-RECORD-TPL	9(11)	13
FILE-SUBMISSION-METHOD	TPL00001	FILE-HEADER-RECORD-TPL	X(2)	14
N/A	TPL00001	FILE-HEADER-RECORD-TPL	X(4)	15
N/A	TPL00001	FILE-HEADER-RECORD-TPL	X(500)	16
RECORD-ID	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(8)	1

STATE	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(2)	2
N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	9(11)	3
N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(20)	4
TPL-HEALTH-INSURANCE-COVERAGE-IND	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(1)	5
TPL-OTHER-COVERAGE-IND	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(1)	6
N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(30)	7
N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(1)	8
N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(30)	9
N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	9(8)	10

N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	9(8)	11
N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(500)	12
RECORD-ID	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(8)	1
STATE	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(2)	2
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	9(11)	3
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(20)	4
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(12)	5
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(20)	6

N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(16)	7
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(20)	8
INSURANCE-PLAN-TYPE	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(2)	9
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	S9(11)V99	10
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(30)	11
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(30)	12
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(9)	13
POLICY-OWNER-CODE	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(2)	14
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	9(8)	15
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	9(8)	16

COVERAGE-TYPE	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(2)	17
N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(500)	18
RECORD-ID	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(8)	1
STATE	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(2)	2
N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	9(11)	3
N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(12)	4
N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(20)	5
INSURANCE-PLAN-TYPE	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(2)	6
COVERAGE-TYPE	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(2)	7

N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	9(8)	8
N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	9(8)	9
N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(500)	10
RECORD-ID	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	X(8)	1
STATE	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	X(2)	2
N/A	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	9(11)	3
N/A	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	X(20)	4

TYPE-OF-OTHER-THIRD-PARTY-LIABILITY	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	X(1)	5
N/A	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	9(8)	6
N/A	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	9(8)	7
N/A	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	X(500)	8
RECORD-ID	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(8)	1
STATE	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(2)	2
N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	9(11)	3
N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(12)	4
TPL-ENTITY-ADDR-TYPE	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(2)	5

N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(60)	6
N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(60)	7
N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(60)	8
N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(28)	9
STATE	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(2)	10
ZIP-CODE	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(9)	11
N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(10)	12
N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	9(8)	13
N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	9(8)	14
N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(10)	15

N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(30)	16
N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(500)	17

Fixed Length Field Start Position	Fixed Length Field Stop Position
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9	18
19	19
20	22
23	31

32	39
40	41
42	49
50	57
58	65
66	66
67	67
68	78

79	82
83	582
1	8
9	10
11	21
22	71
72	121
122	133

134	153
154	154
155	156
157	157
158	158
159	161
162	162
163	182

183	186
187	190
191	198
199	200
201	208

209	216
217	218
219	226
227	234
235	236

237	244
245	252
253	254
255	262
263	270

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273	280
281	288
289	290
291	298

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307	308
309	316
317	318
319	326
327	334
335	335

336	339
340	342
343	345
346	347
348	362
363	370

371	375
376	380
381	385
386	390

391	403
404	416
417	429

430	442
443	455
456	468
469	481
482	482
483	485

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487	488
489	490
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492	493

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507	508

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558	559
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568	575

576	583
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592	599
600	607
608	615
616	623
624	631
632	639
640	647

648	655
656	663
664	671
672	679
680	687
688	695
696	703
704	711
712	719
720	728
729	748

749	778
779	808
809	809
810	817
818	818
819	820
821	840

841	870
871	880
881	892
893	894
895	896
897	906
907	936
937	938

939	950
951	952
953	982
983	992
993	1005
1006	1013
1014	1025

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1028	1032
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1035	1064
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1066	1066
1067	1079
1080	1087
1088	1100
1101	1108

1109	1121
1122	1129
1130	1130
1131	1131
1132	1181
1182	1194
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1763	1775
1776	1788
1789	2288

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383	385
386	403
404	404
405	480

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532	536
537	549

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580	589
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603	615
616	1115
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135	141

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143	642
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687	706

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681	730
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744	751
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765	772
773	782
783	792

793	804
805	834
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836	840
841	841

842	854
855	867
868	880
881	893
894	906
907	908
909	958
959	971
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998	1497
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164	166
167	178

179	191
192	204
205	211
212	224

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238	250
251	263
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134	134

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128	135

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159	166

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104	163
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224	251
252	253
254	262

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266	275
276	375
376	383
384	391
392	891
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161	210
211	212
213	262
263	362

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242	249

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258	265
266	765
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22	41
42	141
142	241

242	271
272	279
280	287
288	295
296	795
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11	21

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93	100
101	108
109	608
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93	592

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80	579

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53	60
61	560
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59	558

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107	606
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353	360
361	860

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131	143
144	151
152	166
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197	198

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301	400
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767	866
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887	894
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956	960

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987	987
988	989
990	1004

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1156	1157
1158	1257
1258	1757
1758	2257
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72	121
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123	130
131	143
144	151
152	166
167	196

197	198
199	298
299	328
329	330
331	430
431	460

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563	574
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595	614
615	634
635	642
643	650
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653	653

654	703
704	708
709	728
729	730

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733	734
735	736
737	751
752	753
754	853
854	1353
1354	1853

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123	130
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144	151
152	166

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197	198
199	298
299	328
329	330
331	430

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575	594
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662	669
670	677
678	679
680	680
681	730

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736	755
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758	759

760	761
762	763
764	778
779	780
781	880
881	1380
1381	1880
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805	812

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823	823
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874	878

879	898
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903	904
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906	907
908	922

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925	1024
1025	1524
1525	2024
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72	121
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123	130
131	143
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152	166
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199	298
299	328

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431	432
433	532
533	562
563	564
565	664
665	764

765	784
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804	853

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859	878
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883	884
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886	887
888	902
903	904
905	954
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957	1056
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1557	2056

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152	166

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433	532
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563	564
565	664
665	764
765	772
773	780
781	782
783	882

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885	885
886	935
936	940
941	960

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963	964
965	966
967	968
969	983
984	1033
1034	1035
1036	1135
1136	1635

1636	2135
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72	121
122	122
123	130
131	143
144	151

152	166
167	196
197	198
199	298
299	328

329	330
331	430
431	432
433	532
533	562
563	564
565	664
665	672

673	680
681	682
683	683
684	733
734	738

739	758
759	760
761	762
763	764
765	766
767	781
782	783

784	883
884	1383
1384	1883
1	8
9	10
11	21
22	71
72	121
122	122
123	130
131	143

144	151
152	166
167	196
197	198
199	298
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431	432
433	532
533	562
563	564
565	664
665	672

673	680
681	682
683	683
684	733
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739	758
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761	762
763	764
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767	781
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784	883
884	1383
1384	1883
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767	866
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1017	1018
1019	1118
1119	1120
1121	1121

1122	1171
1172	1176
1177	1196
1197	1198
1199	1200

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1204	1205
1206	1220
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1271	1272
1273	1372
1373	1872
1873	2372

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58	65

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67	77
78	79
80	83
84	583
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22	33
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106	107
108	109
110	111

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113	115
116	116
117	124

125	132
133	632
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126	185
186	245
246	273
274	275
276	284
285	287
288	297
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358	367

368	867
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72	79
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72	571
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52	551

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52	551
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66	73
74	81
82	581
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78	79
80	83

84	583
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68	167
168	267
268	327

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428	429
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431	460
461	461
462	491
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493	494

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497	504
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513	513
514	514
515	1014
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22	51

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65	72
73	73
74	133
134	193
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254	281

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293	302
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363	372
373	373
374	376
377	876
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154	653
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58	75
76	83
84	91
92	121
122	621
1	8

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11	21
22	51
52	52
53	72
73	80
81	88
89	588

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9	10
11	21
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52	59
60	67
68	69
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72	79

80	579
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82	89
90	97
98	597

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53	102
103	110
111	118
119	618

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74	78
79	578
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81	84
85	584
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42	42
43	43
44	73
74	74
75	104
105	112

113	120
121	620
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11	21
22	41
42	53
54	73

74	89
90	109
110	111
112	124
125	154
155	184
185	193
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196	203
204	211

212	213
214	713
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11	21
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34	53
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56	57

58	65
66	73
74	573
1	8
9	10
11	21
22	41

42	42
43	50
51	58
59	558
1	8
9	10
11	21
22	33
34	35

36	95
96	155
156	215
216	243
244	245
246	254
255	264
265	272
273	280
281	290

291	320
321	820

Coding Requirements
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CIP00001"
1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
1. Value must be 1 character 2. Value must be in Subcaptitation Indicator List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) 3. Mandatory
1. Value must be 9 characters or less 2. Mandatory

1. Value must equal "CLAIM-IP" 2. Mandatory
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created 3. Value must be before associated End of Time Period 4. Mandatory 5. Value of the CC component must be "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be equal to or earlier than associated Date File Created 4. Value must be equal to or after associated Start of Time Period 5. Mandatory
1. Value must be 1 character 2. For production files, value must be equal to "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be a positive integer 3. Value must be between 0:99999999999 (inclusive) 4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory

1. Value must be 4 characters or less 2. Value must between 1 and 9999 3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) 4. Value must not contain a pipe symbol 5. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CIP00002"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CIP.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 12 characters or less 2. Mandatory

1. Value must be 20 characters or less 2. Mandatory 3. Value must match MSIS Identification Number (ELG.021.251) and the Admission Date (CIP.002.094) must be between Enrollment Effective Date (ELG.021.253) and Enrollment End Date (ELG.021.254)
1. Value must be 1 character 2. Value must be in Crossover Indicator List (VVL) 3. If Crossover Indicator value equals "1", then associated Dual Eligible Code (ELG.005.085) value must be in [01,02,04,08,09,10] for the same time period (by date of service) 4. Mandatory
1. Value must be 2 characters 2. Value must be in Type of Hospital List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in 1115A Demonstration Indicator List (VVL) 3. Conditional 4. When value equals "0", is invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.233) must equal "0", is invalid or not populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686"
1. Value must be 3 characters or less 2. Value must be in Adjustment Reason Code List (VVL) 3. Conditional 4. Value must be populated when the total paid amount is different from the total billed amount
1. Value must be 1 character 2. Value must be in Admission Type List (VVL) 3. Mandatory
1. Value must be 20 characters or less 2. Conditional

1. Value must be 4 characters or less 2. Conditional
1. Value must be 4 characters or less 2. The right-most 2 positions must be found in [01-99] 3. Conditional 4. Value must be populated, when associated Diagnosis Related Group (CIP.002.068) is populated
1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag 3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then value must be a valid ICD-9-CM procedure code 4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then value must be a valid ICD-10-CM procedure code 5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code 6. Value must be in Procedure Code List (VVL) 7. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. Conditional 4. When populated, there must be a corresponding Procedure Code 5. If Procedure Code 1 (CIP.002.070) is populated, Procedure Code Flag 1 (CIP.002.072) must be "02" (ICD-9 CM) or "07" (ICD-10 - CM PCS)
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be on or before associated Discharge Date value 3. Value must be provided with an associated Procedure Code value 4. Value must be on or after associated Beginning Date of Service value 5. Value must be on or before associated Eligible Date of Death value 6. Value must be not be populated when associated Procedure Code is not populated 7. Conditional

1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag 3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then value must be a valid ICD-9-CM procedure code 4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then value must be a valid ICD-10-CM procedure code 5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code 6. Value must be in Procedure Code List (VVL) 7. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. Conditional 4. When populated, there must be a corresponding Procedure Code
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be on or before associated Discharge Date value 3. Value must be provided with an associated Procedure Code value 4. Value must be on or after associated Beginning Date of Service value 5. Value must be on or before associated Eligible Date of Death value 6. Value must be not be populated when associated Procedure Code is not populated 7. Conditional
1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag 3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then value must be a valid ICD-9-CM procedure code 4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then value must be a valid ICD-10-CM procedure code 5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code 6. Value must be in Procedure Code List (VVL) 7. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. Conditional 4. When populated, there must be a corresponding Procedure Code

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be on or before associated Discharge Date value 3. Value must be provided with an associated Procedure Code value 4. Value must be on or after associated Beginning Date of Service value 5. Value must be on or before associated Eligible Date of Death value 6. Value must be not be populated when associated Procedure Code is not populated 7. Conditional
1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag 3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then value must be a valid ICD-9-CM procedure code 4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then value must be a valid ICD-10-CM procedure code 5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code 6. Value must be in Procedure Code List (VVL) 7. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. Conditional 4. When populated, there must be a corresponding Procedure Code
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be on or before associated Discharge Date value 3. Value must be provided with an associated Procedure Code value 4. Value must be on or after associated Beginning Date of Service value 5. Value must be on or before associated Eligible Date of Death value 6. Value must be not be populated when associated Procedure Code is not populated 7. Conditional
1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag 3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then value must be a valid ICD-9-CM procedure code 4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then value must be a valid ICD-10-CM procedure code 5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code 6. Value must be in Procedure Code List (VVL) 7. Conditional

1. Value must be 2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. Conditional 4. When populated, there must be a corresponding Procedure Code
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be on or before associated Discharge Date value 3. Value must be provided with an associated Procedure Code value 4. Value must be on or after associated Beginning Date of Service value 5. Value must be on or before associated Eligible Date of Death value 6. Value must be not be populated when associated Procedure Code is not populated 7. Conditional
1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag 3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then value must be a valid ICD-9-CM procedure code 4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then value must be a valid ICD-10-CM procedure code 5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code 6. Value must be in Procedure Code List (VVL) 7. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. Conditional 4. When populated, there must be a corresponding Procedure Code
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be on or before associated Discharge Date value 3. Value must be provided with an associated Procedure Code value 4. Value must be on or after associated Beginning Date of Service value 5. Value must be on or before associated Eligible Date of Death value 6. Value must be not be populated when associated Procedure Code is not populated 7. Conditional

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated Discharge Date value in the claim header 3. Value must be greater than or equal to associated eligible Date of Birth value 4. Value must be less than or equal to associated eligible Date of Death value 5. Mandatory 6. Value must be between Enrollment Effective Date (ELG.021.253) and Enrollment End Date (ELG.021.254) 7. Value must be before Adjudication Date (CIP.003.286)
1. Value must be 2 characters 2. Value must be in Hour List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated Adjudication Date value. 3. Value must be greater than or equal to associated Admission Date value. 4. Value must be greater than or equal to associated eligible Date of Birth value. 5. Value must be less than or equal to associated eligible Date of Death value. 6. Conditional 7. If associated Adjustment Indicator (CIP.002.026) does not equal "1" (Non-denied claims) and Patient Status (CIP.002.199) is not equal to "30" value must be populated. 8. When populated, Discharge Hour (CIP.002.097) must be populated
1. Value must be 2 characters 2. Value must be in Hour List (VVL) 3. Conditional 4. When populated, Discharge Date (CIP.002.096) must be populated
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CIP.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Total Medicaid Paid Amount 3. Mandatory
1. Value must be 1 character 2. Value must be in Type of Claim List (VVL) 3. Mandatory

1. Value must be 4 characters 2. Value must be in Type of Bill List (VVL) 3. First character must be a "0" 4. Mandatory
1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) 3. Conditional 4. If value in [542,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be "F2"
1. Value must be 3 characters or less 2. Value must be in Claim Status Category List (VVL) 3. (Denied Claim) if associated Claim Denied Indicator indicates the claim was denied, then value must be "F2" 4. (Denied Claim) if associated Claim Status is in [542,585,654], then value must be "F2" 5. Mandatory
1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional

1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique
1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 1 (CIP.002.108) is not populated
1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 2 (CIP.002.109) is not populated
1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 3 (CIP.002.110) is not populated

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must equal the sum of all Billed Amount instances for the associated claim 4. Conditional 5. (individual line item payments) when populated and Payment Level Indicator (CIP.002.132) equals "2" value must be greater than or equal to the sum of all claim line Revenue Charges (CIP.003.251)
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. When populated and Payment Level Indicator equals "2", then value must equal the sum of all claim line Allowed Amount values 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Must have an associated Medicaid Paid Date 4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount 5. When Payment Level Indicator equals "2", value must equal the sum of line level Medicaid Paid Amounts. 6. Conditional 7. Value must not be populated or equal to "0.00" when associated Claim Status is in [542,585,654] 8. Value must not be greater than Total Allowed Amount (CIP.002.113)

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0" (not a crossover claim), then value should not be populated 4. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in [01,02,03,04,05,06,08,09,10], then value is mandatory and must be provided 5. Conditional 6. When populated, value must be less than or equal to Total Billed Amount
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0" (not a crossover claim), then value should not be populated. 4. Conditional 5. If associated Medicare Combined Deductible Indicator equals "1", then value must not be populated 6. When populated, value must be less than or equal to Total Billed Amount
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than associated Total Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount) 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 1 character 2. Value must be in Other Insurance Indicator List (VVL) 3. Value must be in [0,1] or not populated 4. Conditional
1. Value must be in Other TPL Collection List (VVL) 2. Value must be 3 characters 3. Mandatory

1. Value must be 1 character 2. Value must be in Fixed Payment Indicator List (VVL) 3. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. If Type of Claim is not in [3,C,W], then value must be populated 4. Conditional
1. Value must be 2 characters 2. Value must be in Funding Source Non-Federal Share List (VVL) 3. If Type of Claim is in [3,C,W], then value must be populated 4. Conditional
1. Value must be 1 character 2. Value must be in Medicare Combined Deductible Indicator List (VVL) 3. If value equals "1", then Total Medicare Coinsurance amount must not be populated 4. If value equals "0", then Crossover Indicator must equals "0" 5. If value equals "1", then Crossover Indicator must equals "1" 6. Conditional
1. Value must be 2 characters 2. Value must be in Program Type List (VVL) 3. Mandatory 4. (Community First Choice) If value equals "11", then State Plan Option Type (ELG.011.163) must equal "01" for the same time period 5. If value equals "13", then State Plan Option Type (ELG.011.163) must equal "02" for the same time period

1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional 4. Value must match Managed Care Plan ID (ELG.014.192) 5. Value must match State Plan ID Number (MCR.002.019) 6. When Type of Claim (CIP.002.100) in [3,C,W] value must have a managed care enrollment (ELG.014) for the beneficiary where the Admission Date (CIP.002.094) occurs between the managed care plan enrollment eff/end dates (ELG.014.197/198) 7. When Type of Claim (CIP.002.100) in [3,C,W] value must have a managed care main record (MCR.002) for the plan where the Admission Date (CIP.002.094) occurs between the managed care contract eff/end dates (MCR.002.020/021)
1. Value must be 1 character 2. Value must be in Payment Level Indicator List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Medicare Reimbursement Type List (VVL) 3. Value is mandatory and must be provided, when Crossover Indicator is equal to "1" (Crossover Claim) 4. Conditional

1. Value must be 5 digits or less 2. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be a positive integer 2. Value must be between 0000000:9999999 (inclusive) 3. Conditional 4. Value must be less than or equal to double the number of days between Admission Date Discharge Date (CIP.002.094) and Discharge Date Discharge Date (CIP.002.096) plus one day 5. Value must be 7 digits or less 6. Value is required if the associated Type of Service (CIP.002.257) in [001,058,060,084,086,090,091,092,093] 7. Value is required if at least one associated Revenue Code (CIP.003.245) in [100-219]
1. Value must be 4 characters or less 2. Value must be a positive integer 3. Value must be between 0000:9999 (inclusive) 4. Value must not include commas or other non-numeric characters 5. Value must be equal to the number of claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported 6. Mandatory
1. Value must be 1 character 2. Value must be in Forced Claim Indicator List (VVL) 3. Conditional
1. Value must be 1 character 2. Value must be in Healthcare Acquired Condition Indicator List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) 3. Conditional

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1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code 3. Conditional 4. Value must be less than or equal to Occurrence Code End Date
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code 3. Conditional 4. Value must be less than or equal to Occurrence Code End Date

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1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code 3. Conditional 4. Value must be less than or equal to Occurrence Code End Date
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
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1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
1. Value must not be greater than 6 digits to the left of the decimal and have no more than 3 digits to the right of the decimal (i.e. 999999.999) 2. Conditional
1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Conditional

1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 1 character 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory
1. Value must be in Health Home Provider Indicator List (VVL) 2. Value must be 1 character 3. If there is an associated Health Home Entity Name value, then value must be "1" 4. Conditional
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period (by date of service) 4. Value must have a corresponding value in Waiver ID (CIP.002.178) 5. Conditional
1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33] 6. Conditional

1. Value must be 30 characters or less 2. Conditional 3. When Type of Claim not in [3,C,W] then value may match (PRV.002.019) Submitting State Provider ID or 4. When Type of Claim not in [3,C,W] then value may match (PRV.005.081) Provider Identifier where the Provider Identifier Type (PRV.005.077) equals "1" 5. Discharge Date (CIP.002.096) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or 6. Discharge Date (CIP.002.096) may be between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL) 3. Conditional
1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File
1. Value must be 30 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL) 3. Conditional

1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 3. Conditional
1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 3. Conditional
1. Value must be 30 characters or less 2. Conditional
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be populated when Outlier Code (CIP.002.197) is in [01,02,10] 4. Conditional
1. Value may include up to 3 digits to the left of the decimal point, and 5 digits to the right e.g. 123.45678 2. Conditional 3. When populated value must be zero or greater
1. Value must be 12 characters or less 2. Conditional 3. Value must not contain a pipe or asterisk symbols 4. (Not Dual Eligible) if Dual Eligible Code (ELG.DE.085) value equals "00", then value must not be populated 5. Value must be populated when Crossover Indicator (CIP.002.023) equals "1" and Medicare Beneficiary Identifier (CIP.002.222) is not populated

1. Value must be 2 characters 2. Value must be in Outlier Code List (VVL) 3. Value is mandatory if either DRG Outlier Amount (CIP.002.194) or Outlier Days (CIP.002.198) are populated 4. Conditional
1. Value must be 5 digits or less 2. Value must be numeric 3. Value must be populated, if Outlier Code (CIP.002.197) equals "01" 4. Conditional
1. Value must be 2 characters 2. Value must be in Patient Status List (VVL) 3. Mandatory 4. When value in [20,40,41,42], then associated Discharge Date (CIP.002.096) must be less than or equal to Date of Death (ELG.002.025)
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 1 character 2. Value must be in Split Claim Indicator List (VVL) 3. Conditional
1. Value must be 1 character 2. Value must be in Border State Indicator List (VVL) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Coinsurance Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Copayment Amount 3. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Deductible Amount 3. Conditional
1. Value must be 1 character 2. Value must be in Claim Denied Indicator List (VVL) 3. If value equals "0", then Claim Status Category must equal "F2" 4. Mandatory
1. Value must be 1 character 2. Value must be in Copay Waived Indicator List (VVL) 3. Situational
1. Value must not contain a pipe or asterisk symbols 2. Value must 50 characters or less 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Situational
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Coinsurance Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Situational
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Copayment Amount 3. Situational

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 10 digits 2. Value must have an associated Provider Identifier, where Provider Identifier Type (PRV.005.077) equals "2" 3. Value must exist in the NPPES NPI data file 4. Conditional
1. Conditional 2. Value must be an 11-character string 3. Character 1 must be numeric values 1 thru 9 4. Character 2 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 5. Character 3 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 6. Character 4 must be numeric values 0 thru 9 7. Character 5 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 8. Character 6 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 9. Character 7 must be numeric values 0 thru 9 10. Character 8 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 11. Character 9 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 12. Character 10 must be numeric values 0 thru 9 13. Character 11 must be numeric values 0 thru 9 14. Value must not contain a pipe or asterisk symbols
1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0", then the value must not be populated 4. Conditional 5. If value is populated, Crossover Indicator must be equal to "1"

1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be less than or equal to associated Ending Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be less than or equal to at least one of the eligible's Enrollment End Date (ELG.021.254) values 7. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be greater than or equal to associated Beginning Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value 7. Mandatory
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must not be more than 60 characters long 2. Mandatory 3. Value must not contain a pipe or asterisk symbols
1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. Value must not contain a pipe or asterisk symbols 5. There must be an Address Line 1 in order to have an Address Line 2
1. Value must not be more than 28 characters long 2. Mandatory
1. Value must not be more than 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory
1.Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
1. Value must not be more than 60 characters long 2. Conditional 3. Value must not contain a pipe or asterisk symbols

1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. There must be an Address Line 1 in order to have an Address Line 2 5. Value must not contain a pipe or asterisk symbols
1. Value must not be more than 28 characters long 2. Conditional
1. Value must not be more than 2 characters 2. Value must be in State Code List (VVL) 3. Conditional
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional
1. Value must not be more than 2 characters 2. Value must be in Provider Claim Form Code List (VVL) 3. Mandatory
1. Value must not be more than 50 characters long 2. Conditional 3. Value must be provided when corresponding Provider Claim Form Code is "Other"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CIP00003"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CIP.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 3 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory 4. Value must be one or greater

1. Value must be 3 characters or less 2. If associated Line Adjustment Indicator value equals "0", then value must not be populated 3. If associated Line Adjustment Indicator value equals "1", then value is mandatory and must be provided 4. Conditional 5. When populated, value must be one or greater
1. Value must be 1 character 2. Value must be in Line Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Conditional 5. If associated Line Adjustment Number is populated, then value must be populated
1. Value must be 3 characters or less 2. Value must be in Line Adjustment Reason Code List (VVL) 3. Conditional 4. Value must be populated when the total paid amount is different from the total billed amount
1. Value must be 12 characters or less 2. Mandatory
1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) 3. Conditional 4. If value in [545,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be"F2"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be less than or equal to associated Ending Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be less than or equal to at least one of the eligible's Enrollment End Date (ELG.021.254) values 7. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be greater than or equal to associated Beginning Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value 7. Mandatory
1. Value must be 4 characters or less 2. Value must be in Revenue Code List (VVL) 3. A Revenue Code value requires an associated Revenue Charge 4. Mandatory
1. Value must be numeric 2. Value may include up to 6 digits to the left of the decimal point, and 3 digits to the right e.g. 123456.789 3. Mandatory
1. Value must be numeric 2. Value may include up to 6 digits to the left of the decimal point, and 3 digits to the right, e.g. 123456.789 3. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than or equal to associated Total Billed Amount value. 4. When populated, associated claim line Revenue Charge must be populated 5. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional 4. Value should not be populated or should be equal to zero, when associated Claim Line Status is in [542,585,654]
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Type of Claim value in [3,C,W], then value is mandatory and must be provided 4. Conditional

1. Value must be 2 characters 2. Value must be in Billing Unit List (VVL) 3. Conditional
1. Value must be 3 characters 2. Mandatory 3. Value must be in Type of Service IP List (VVL) 4. If Sex (ELG.002.023) equals "M", then value must not equal "086"
1. Value must be 30 characters or less 2. Conditional 3. When Type of Claim not in [3,C,W], then value may match (PRV.005.081) Provider Identifier or 4. When Type of Claim not in [3,C,W], then value may match (PRV.002.019) Submitting State Provider ID
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional
1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL) 3. Conditional
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Conditional 4. Value must exist in the NPPES NPI data file
1. Value must be 3 characters 2. Value must be in Other TPL Collection List (VVL) 3. Mandatory
1. Value must be 9 characters or less 2. Value must be in Provider Facility Type List (VVL) 3. Mandatory

1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. (Federal Funding under Title XXI) if value equals "02", then the eligible's CHIP Code (ELG.003.054) must be in [2,3] 4. (Federal Funding under Title XIX) if value equals "01" then the eligible's CHIP Code (ELG.003.054) must be "1" 5. Conditional 6. If Type of Claim is in [1,A,U] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value may include up to 9 digits to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789 2. Conditional
1. Value must be 12 digits or less 2. Value must be a valid National Drug Code 3. Conditional
1. Value must be 2 characters 2. Value must be in NDC Unit of Measure List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CRX.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. Value must be 3 characters 2. Value must be in Self Direction Type List (VVL) 3. Mandatory
1. Value must be 18 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 1 character 2. Value must be in the IHS Service Indicator List (VVL) 3. Mandatory
1. Value must not be more than 76 characters long 2. Conditional

1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Conditional 4. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Conditional 6. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0
1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Conditional 11. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

1. Value must be 30 characters or less 2. Conditional
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CIP00004"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CIP.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686" 7. Value must match the adjustment indicator in the header (CIP.002.026)
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CIP.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. Value must be 1 character 2. Value must be in Diagnosis Type Code List (VVL) 3. Value must be in [P,A,E,O] 4. Mandatory
1. Value must be in [01-24] 2. Mandatory
1. Value must be 1 character 2. Value must be in Diagnosis Code Flag List (VVL) 3. Mandatory
1. Value must be a minimum of 3 characters 2. If associated Diagnosis Code Flag value equals "1" (ICD-9), then value must be in ICD-9 Diagnosis Code List (VVL) 3. If associated Diagnosis Code Flag value equals "2" (ICD-10), then value must be in ICD-10 Diagnosis Code List (VVL) 4. Value must not contain a decimal point 5. Mandatory

1. Value must be 1 character 2. Value must be in Diagnosis POA Flag List (VVL) 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CLT00001"
1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
1. Value must be 1 character 2. Value must be in Subcaptitation Indicator List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) 3. Mandatory
1. Value must be 9 characters or less 2. Mandatory
1. Value must equal "CLAIM-LT" 2. Mandatory
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created 3. Value must be before associated End of Time Period 4. Mandatory 5. Value of the CC component must be "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be equal to or earlier than associated Date File Created 4. Value must be equal to or after associated Start of Time Period 5. Mandatory
1. Value must be 1 character 2. For production files, value must be equal to "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be a positive integer 3. Value must be between 0:99999999999 (inclusive) 4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
1. Value must be 4 characters or less 2. Value must between 1 and 9999 3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) 4. Value must not contain a pipe symbol 5. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CLT00002"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CLT.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 12 characters or less 2. Mandatory
1. Mandatory 2. Value must be 20 characters or less. 3. The Beginning Date of Service on the claim must fall between (ELG.021.253) enrollment effective and (ELG.021.253) end date

1. Value must be 1 character 2. Value must be in Crossover Indicator List (VVL) 3. If Crossover Indicator value equals "1", then associated Dual Eligible Code (ELG.005.085) value must be in [01,02,04,08,09,10] for the same time period (by date of service) 4. Mandatory
1. Value must be 1 character 2. Value must be in 1115A Demonstration Indicator List (VVL) 3. Conditional 4. When value equals "0", is invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.233) must equal "0", is invalid or not populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686" 7. Value must match the adjustment indicator in the header (CIP.002.026)
1. Value must be 3 characters or less 2. Value must be in Adjustment Reason Code List (VVL) 3. Conditional 4. Value must be populated when the total paid amount is different from the total billed amount
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated Discharge Date value in the claim header 3. Value must be greater than or equal to associated eligible Date of Birth value 4. Value must be less than or equal to associated eligible Date of Death value 5. Mandatory 6. Value must be before Adjudication Date (CLT.002.050)
1. Value must be 2 characters 2. Value must be in Hour List (VVL) 3. Conditional

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated Adjudication Date value. 3. Value must be greater than or equal to associated Admission Date value. 4. Value must be greater than or equal to associated eligible Date of Birth value. 5. Value must be less than or equal to associated eligible Date of Death value. 6. Conditional 7. When populated, Discharge Hour (CLT.002.047) must be populated
1. Value must be 2 characters 2. Value must be in Hour List (VVL) 3. Conditional 4. When populated, Discharge Date (CLT.002.046) must be populated
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be less than or equal to associated Ending Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be less than or equal to at least one of the eligible's Enrollment End Date (ELG.021.254) values 7. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be greater than or equal to associated Beginning Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value 7. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CIP.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Total Medicaid Paid Amount 3. Mandatory

1. Value must be 1 character 2. Value must be in Type of Claim List (VVL) 3. Mandatory
1. Value must be 4 characters 2. Value must be in Type of Bill List (VVL) 3. First character must be a "0" 4. Mandatory
1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) 3. Conditional 4. If value in [542,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be "F2"
1. Value must be 3 characters or less 2. Value must be in Claim Status Category List (VVL) 3. (Denied Claim) if associated Claim Denied Indicator indicates the claim was denied, then value must be "F2" 4. (Denied Claim) if associated Claim Status is in [542,585,654], then value must be "F2" 5. Mandatory
1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional

1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique
1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 1 (CLT.002.059) is not populated
1. Value must be in Claim Payment Remittance Code List (VVL) 2. Value must be 5 characters or less 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 2 (CLT.002.060) is not populated
1. Value must be in Claim Payment Remittance Code List (VVL) 2. Value must be 5 characters or less 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 3 (CLT.002.061) is not populated

1. Value must be between -99999999999.99 and 99999999999.99. 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50). 3. Value must equal the sum of all Billed Amount instances for the associated claim. 4. Conditional 5. (individual line item payments) when populated and Payment Level Indicator (CLT.002.082) equals = '2' value must be greater than or equal to the sum of all claim line Revenue Charges (CLT.003.204).
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. When populated and Payment Level Indicator equals "2", then value must equal the sum of all claim line Allowed Amount values 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Must have an associated Medicaid Paid Date 4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount 5. When Payment Level Indicator equals "2", value must equal the sum of line level Medicaid Paid Amounts. 6. Conditional 7. Value must not be populated or equal to "0.00" when associated Claim Status is in [542,585,654] 8. Value must not be greater than Total Allowed Amount (CLT.002.064)

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0" (not a crossover claim), then value should not be populated 4. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in [01,02,03,04,05,06,08,09,10], then value is mandatory and must be provided 5. Conditional 6. When populated, value must be less than or equal to Total Billed Amount
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0" (not a crossover claim), then value should not be populated. 4. Conditional 5. If associated Medicare Combined Deductible Indicator equals "1", then value must not be populated 6. When populated, value must be less than or equal to Total Billed Amount
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than associated Total Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount) 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 1 character 2. Value must be in Other Insurance Indicator List (VVL) 3. Conditional
1. Value must be in Other TPL Collection List (VVL) 2. Value must be 3 characters 3. Mandatory

1. Value must be 1 character 2. Value must be in Fixed Payment Indicator List (VVL) 3. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. If Type of Claim is not in [3,C,W], then value must be populated 4. Conditional
1. Value must be 2 characters 2. Value must be in Funding Source Non-Federal Share List (VVL) 3. If Type of Claim is in [3,C,W], then value must be populated 4. Conditional
1. Value must be 1 character 2. Value must be in Medicare Combined Deductible Indicator List (VVL) 3. If value equals "1", then Total Medicare Coinsurance amount must not be populated 4. If value equals "0", then Crossover Indicator must equals "0" 5. If value equals "1", then Crossover Indicator must equals "1" 6. Conditional
1. Value must be 2 characters 2. Value must be in Program Type List (VVL) 3. Mandatory 4. (Community First Choice) If value equals "11", then State Plan Option Type (ELG.011.163) must equal "01" for the same time period 5. If value equals "13", then State Plan Option Type (ELG.011.163) must equal "02" for the same time period

1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional 4. Value must match Managed Care Plan ID (ELG.014.192). 5. Value must match State Plan ID Number (MCR.002.019). 6. Value should not be populated when Type of Claim is not in [3,C,W] 7. When Type of Claim in [3,C,W] value must have a managed care enrollment (ELG.014) for the beneficiary where the Beginning DOS (CLT.002.048) occurs between the managed care plan enrollment eff/end dates (ELG.014.197/198) 8. When Type of Claim in [3,C,W] value must have a managed care main record (MCR.002) for the plan where the Beginning DOS (CLT.002.048) occurs between the managed care contract eff/end dates (MCR.002.020/021)
1. Value must be 1 character 2. Value must be in Payment Level Indicator List (VVL) 3. Mandatory

1. Value must be 2 characters 2. Value must be in Medicare Reimbursement Type List (VVL) 3. Value is mandatory and must be provided, when Crossover Indicator is equal to "1" (Crossover Claim) 4. Conditional
1. Value must be 5 digits or less 2. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be a positive integer 2. Value must be between 00000:99999 (inclusive) 3. Conditional 4. Value must be less than or equal to double the number of days between Admission Date (CLT.002.044) and Discharge Date (CLT.002.046) plus one day 5. Value must be 5 digits or less 6. (inpatient mental health/psychiatric services) when associated Type of Service (CLT.003.211) in [044,048,050], this field must be populated
1. Value must be 4 characters or less 2. Value must be a positive integer 3. Value must be between 0000:9999 (inclusive) 4. Value must not include commas or other non-numeric characters 5. Value must be equal to the number of claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported 6. Mandatory
1. Value must be 1 character 2. Value must be in Forced Claim Indicator List (VVL) 3. Conditional
1. Value must be 1 character 2. Value must be in Healthcare Acquired Condition Indicator List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) 3. Conditional

1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) 3. Conditional
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1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code 3. Conditional 4. Value must be less than or equal to Occurrence Code End Date

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code 3. Conditional 4. Value must be less than or equal to Occurrence Code End Date
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1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
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1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Conditional

1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 1 character 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory
1. Value must be in Health Home Provider Indicator List (VVL) 2. Value must be 1 character 3. If there is an associated Health Home Entity Name value, then value must be "1" 4. Conditional
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period (by date of service) 4. Value must have a corresponding value in Waiver ID (CLT.002.129) 5. Conditional
1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33] 6. Conditional

1. Value must be 30 characters or less 2. Conditional 3. When Type of Claim not in [3,C,W] then value may match (PRV.002.019) Submitting State Provider ID or 4. When Type of Claim not in [3,C,W] then value may match (PRV.005.081) Provider Identifier where the Provider Identifier Type (PRV.005.077) equals "1" 5. Discharge Date (CIP.002.096) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or 6. Discharge Date (CIP.002.096) may be between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL) 3. Conditional
1. Value must be 30 characters or less 2. Conditional
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional

1. Value must be 12 characters or less 2. Conditional 3. Value must not contain a pipe or asterisk symbols 4. (Not Dual Eligible) if Dual Eligible Code (ELG.DE.085) value equals "00", then value must not be populated 5. Value must be populated when Crossover Indicator (CLT.002.023) equals "1" and Medicare Beneficiary Identifier (CLT.002.168) is not populated
1. Value must be 2 characters 2. Value must be in Patient Status List (VVL) 3. Mandatory
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 5 digits or less 2. Conditional 3. Value is mandatory when associated Type of Service (CLT.003.211) equals "046" 4. Value must be less than or equal to the number of days between (ending date of service minus beginning date of service) plus one day 5. When populated, if value is greater than 0 and less than 99998, then Level of Care Status (ELG.005.088) for the associated MSIS Identification Number (CLT.002.022) must equal "004" (ICF/IID) for the same month as the begin and end date of service
1. Value must be numeric 2. Value must be 5 digits or less 3. Conditional 4. (Intermediate Care Facility for Individuals with Intellectual Disabilities) value is required when Type of Service (CLT.003.211) in [009,045,046,047,059]

1. Value must be 5 digits or less 2. Value must be numeric 3. Conditional 4. When populated, value must be less than or equal to the number of days between (ending date of service minus beginning date of service) plus one day 5. (nursing facility) value is required when the Type of Service in [009,045,047,059] 6. When populated, if value is greater than zero, then Level of Care Status (ELG.005.088) for the associated MSIS Identification Number (CLT.002.022) must equal "003" (Nursing Facility) for the same month as the beginning and ending date of service
1. Value must be 1 character 2. Value must be in Split Claim Indicator List (VVL) 3. Conditional
1. Value must be 1 character 2. Value must be in Border State Indicator List (VVL) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Coinsurance Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Copayment Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Deductible Amount 3. Conditional

1. Value must be 1 character 2. Value must be in Claim Denied Indicator List (VVL) 3. If value equals "0", then Claim Status Category must equal "F2" 4. Mandatory
1. Value must be 1 character 2. Value must be in Copay Waived Indicator List (VVL) 3. Situational
1. Value must not contain a pipe or asterisk symbols 2. Value must 50 characters or less 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Situational
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Coinsurance Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Situational
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Copayment Amount 3. Situational
1. Value must be 12 digits 2. Value must have an associated Provider Identifier, where Provider Identifier Type (PRV.005.077) equals "2" 3. Value must exist in the NPPES NPI data file 4. Conditional

1. Conditional 2. Value must be an 11-character string 3. Character 1 must be numeric values 1 thru 9 4. Character 2 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 5. Character 3 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 6. Character 4 must be numeric values 0 thru 9 7. Character 5 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 8. Character 6 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 9. Character 7 must be numeric values 0 thru 9 10. Character 8 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 11. Character 9 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 12. Character 10 must be numeric values 0 thru 9 13. Character 11 must be numeric values 0 thru 9 14. Value must not contain a pipe or asterisk symbols
1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File
1. Value must be 30 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL) 3. Conditional
1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 3. Conditional
1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0", then the value must not be populated 4. Conditional 5. If value is populated, Crossover Indicator must be equal to "1"

1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must not be more than 60 characters long 2. Mandatory 3. Value must not contain a pipe or asterisk symbols
1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. Value must not contain a pipe or asterisk symbols 5. There must be an Address Line 1 in order to have an Address Line 2
1. Value must not be more than 28 characters long 2. Mandatory
1. Value must not be more than 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory

1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory
1.Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
1. Value must not be more than 60 characters long 2. Conditional 3. Value must not contain a pipe or asterisk symbols
1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. There must be an Address Line 1 in order to have an Address Line 2 5. Value must not contain a pipe or asterisk symbols
1. Value must not be more than 28 characters long 2. Conditional
1. Value must not be more than 2 characters 2. Value must be in State Code list (VVL) 3. Conditional
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional
1. Value must not be more than 2 characters 2. Value must be in Provider Claim Form Code List (VVL) 3. Mandatory
1. Value must not be more than 50 characters long 2. Conditional 3. Value must be provided when corresponding Provider Claim Form Code is "Other"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CLT00003"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CLT.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory

1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 3 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory 4. Value must be one or greater
1. Value must be 3 characters or less 2. If associated Line Adjustment Indicator value equals "0", then value must not be populated 3. If associated Line Adjustment Indicator value equals "1", then value is mandatory and must be provided 4. Conditional 5. When populated, value must be one or greater
1. Value must be 1 character 2. Value must be in Line Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Conditional 5. If associated Line Adjustment Number is populated, then value must be populated
1. Value must be 3 characters or less 2. Value must be in Line Adjustment Reason Code List (VVL) 3. Conditional 4. Value must be populated when the total paid amount is different from the total billed amount
1. Value must be 12 characters or less 2. Mandatory
1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) 3. Conditional 4. If value in [545,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be"F2"

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be less than or equal to associated Ending Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be less than or equal to at least one of the eligible's Enrollment End Date (ELG.021.254) values 7. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be greater than or equal to associated Beginning Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value 7. Mandatory
1. Value must be 4 characters or less 2. Value must be in Revenue Code List (VVL) 3. A Revenue Code value requires an associated Revenue Charge 4. Mandatory
1. Value must be numeric 2. Value may include up to 6 digits to the left of the decimal point, and 3 digits to the right e.g. 123456.789 3. Mandatory

1. Value must be numeric 2. Value may include up to 6 digits to the left of the decimal point, and 3 digits to the right, e.g. 123456.789 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than or equal to associated Total Billed Amount value. 4. When populated, associated claim line Revenue Charge must be populated 5. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional 4. Value should not be populated or should be equal to zero, when associated Claim Line Status is in [542,585,654]
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Type of Claim value in [3,C,W], then value is mandatory and must be provided 4. Conditional
1. Value must be 2 characters 2. Value must be in Billing Unit List (VVL) 3. Conditional
1. Value must be 3 characters 2. Mandatory 3. Value must be in Type of Service LT List (VVL)
1. Value must be 30 characters or less 2. Conditional 3. When Type of Claim not in [3,C,W], then value may match (PRV.005.081) Provider Identifier or 4. When Type of Claim not in [3,C,W], then value may match (PRV.002.019) Submitting State Provider ID
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Conditional 4. If Type of Claim (CLT.002.052) not in [3,C,W], then value must match Provider Identifier (PRV.005.081) 5. Value must exist in the NPPES NPI data file
1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL). 3. Conditional

1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL) 3. Conditional
1. Value must be 3 characters 2. Value must be in Other TPL Collection List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. (Federal Funding under Title XXI) if value equals "02", then the eligible's CHIP Code (ELG.003.054) must be in [2,3] 4. (Federal Funding under Title XIX) if value equals "01" then the eligible's CHIP Code (ELG.003.054) must be "1" 5. Conditional 6. If Type of Claim is in [1,A,U] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported
1. Value must be 9 characters or less 2. Value must be in Provider Facility Type List (VVL) 3. Mandatory
1. Value must be 12 digits or less 2. Value must be a valid National Drug Code 3. Conditional
1. Value must be 2 characters 2. Value must be in NDC Unit of Measure List (VVL) 3. Conditional
1. Value may include up to 9 digits to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789 2. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CLT.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. Value must be 3 characters 2. Value must be in Self Direction Type List (VVL) 3. Mandatory
1. Value must be 18 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 1 character 2. Value must be in the IHS Service Indicator List (VVL) 3. Mandatory

1. Value must not be more than 76 characters long 2. Conditional
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Conditional 4. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Conditional 6. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0
1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Conditional 11. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

1. Value must be 30 characters or less 2. Conditional
1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CLT00004"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CLT.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686" 7. Value must match the adjustment indicator in the header (CLT.002.025)
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CLT.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. Value must be 1 character 2. Value must be in Diagnosis Type Code List (VVL) 3. Value must be in [P,A,E,O] 4. Mandatory
1. Value must be in [01-24] 2. Mandatory
1. Value must be 1 character 2. Value must be in Diagnosis Code Flag List (VVL) 3. Mandatory
1. Value must be a minimum of 3 characters 2. If associated Diagnosis Code Flag value equals "1" (ICD-9), then value must be in ICD-9 Diagnosis Code List (VVL) 3. If associated Diagnosis Code Flag value equals "2" (ICD-10), then value must be in ICD-10 Diagnosis Code List (VVL) 4. Value must not contain a decimal point 5. Mandatory

1. Value must be 1 character 2. Value must be in Diagnosis POA Flag List (VVL) 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "COT00001"
1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
1. Value must be 1 character 2. Value must be in Subcaptitation Indicator List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) 3. Mandatory
1. Value must be 9 characters or less 2. Mandatory
1. Value must equal "CLAIM-OT" 2. Mandatory
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created 3. Value must be before associated End of Time Period 4. Mandatory 5. Value of the CC component must be "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be equal to or earlier than associated Date File Created 4. Value must be equal to or after associated Start of Time Period 5. Mandatory
1. Value must be 1 character 2. For production files, value must be equal to "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be a positive integer 3. Value must be between 0:99999999999 (inclusive) 4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
1. Value must be 4 characters or less 2. Value must between 1 and 9999 3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) 4. Value must not contain a pipe symbol 5. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "COT00002"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (COT.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 12 characters or less 2. Mandatory
1. Value must be 20 characters or less 2. Mandatory 3. Value must match MSIS Identification Number (ELG.021.251) and the Beginning Date of Service (COT.002.033) must be between Enrollment Effective Date (ELG.021.253) and Enrollment End Date (ELG.021.254)

1. Value must be 1 character 2. Value must be in Crossover Indicator List (VVL) 3. If Crossover Indicator value equals "1", then associated Dual Eligible Code (ELG.005.085) value must be in [01,02,04,08,09,10] for the same time period (by date of service) 4. Mandatory
1. Value must be 1 character 2. Value must be in 1115A Demonstration Indicator List (VVL) 3. Conditional 4. When value equals "0", is invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.233) must equal "0", is invalid or not populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686"
1. Value must be 3 characters or less 2. Value must be in Adjustment Reason Code List (VVL) 3. Conditional 4. Value must be populated when the total paid amount is different from the total billed amount
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be less than or equal to associated Ending Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be less than or equal to at least one of the eligible's Enrollment End Date (ELG.021.254) values 7. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be greater than or equal to associated Beginning Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value 7. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CIP.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Total Medicaid Paid Amount 3. Mandatory
1. Value must be 1 character 2. Value must be in Type of Claim List (VVL) 3. Mandatory
1. Value must be 4 characters 2. Value must be in Type of Bill List (VVL) 3. First character must be a "0" 4. Conditional
1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) 3. Conditional 4. If value in [542,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be "F2"
1. Value must be 3 characters or less 2. Value must be in Claim Status Category List (VVL) 3. (Denied Claim) if associated Claim Denied Indicator indicates the claim was denied, then value must be "F2" 4. (Denied Claim) if associated Claim Status is in [542,585,654], then value must be "F2" 5. Mandatory

1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional
1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique
1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 1 (COT.002.044) is not populated

1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 2 (CLT.002.045) is not populated
1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 3 (COT.002.046) is not populated
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must equal the sum of all Billed Amount instances for the associated claim 4. Conditional 5. (individual line item payments) when populated and Payment Level Indicator (COT.002.068) equals "2" value must be greater than or equal to the sum of all claim line Revenue Charges (COT.003.168)
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. When populated and Payment Level Indicator equals "2", then value must equal the sum of all claim line Allowed Amount values 4. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Must have an associated Medicaid Paid Date 4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount 5. When Payment Level Indicator equals "2", value must equal the sum of line level Medicaid Paid Amounts. 6. Conditional 7. Value must not be populated or equal to "0.00" when associated Claim Status is in [542,585,654] 8. Value must not be greater than Total Allowed Amount (COT.002.049)
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0" (not a crossover claim), then value should not be populated 4. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in [01,02,03,04,05,06,08,09,10], then value is mandatory and must be provided 5. Conditional 6. When populated, value must be less than or equal to Total Billed Amount
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0" (not a crossover claim), then value should not be populated. 4. Conditional 5. If associated Medicare Combined Deductible Indicator equals "1", then value must not be populated 6. When populated, value must be less than or equal to Total Billed Amount
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than associated Total Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount) 4. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 1 character 2. Value must be in Other Insurance Indicator List (VVL) 3. Conditional
1. Value must be in Other TPL Collection List (VVL) 2. Value must be 3 characters 3. Mandatory
1. Value must be 1 character 2. Value must be in Fixed Payment Indicator List (VVL) 3. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. If Type of Claim is not in [3,C,W], then value must be populated 4. Conditional
1. Value must be 2 characters 2. Value must be in Funding Source Non-Federal Share List (VVL) 3. If Type of Claim is in [3,C,W], then value must be populated 4. Conditional
1. Value must be 1 character 2. Value must be in Medicare Combined Deductible Indicator List (VVL) 3. If value equals "1", then Total Medicare Coinsurance amount must not be populated 4. If value equals "0", then Crossover Indicator must equals "0" 5. If value equals "1", then Crossover Indicator must equals "1" 6. Conditional

1. Value must be 2 characters 2. Value must be in Program Type List (VVL) 3. Mandatory 4. (Community First Choice) If value equals "11", then State Plan Option Type (ELG.011.163) must equal "01" for the same time period 5. If value equals "13", then State Plan Option Type (ELG.011.163) must equal "02" for the same time period
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional 4. Value must match Managed Care Plan ID (ELG.014.192) 5. Value must match State Plan ID Number (MCR.002.019) 6. When Type of Claim (COT.002.037) in [3,C,W] value must have a managed care enrollment (ELG.014) for the beneficiary where the Beginning DOS (COT.002.033) occurs between the managed care plan enrollment eff/end dates (ELG.014.197/198) 7. When Type of Claim (COT.002.037) in [3,C,W] value must have a managed care main record (MCR.002) for the plan where the Beginning DOS (COT.002.037) occurs between the managed care contract eff/end dates (MCR.002.020/021)

1. Value must be 1 character 2. Value must be in Payment Level Indicator List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Medicare Reimbursement Type List (VVL) 3. Value is mandatory and must be provided, when Crossover Indicator is equal to "1" (Crossover Claim) 4. Conditional
1. Value must be 4 characters or less 2. Value must be a positive integer 3. Value must be between 0000:9999 (inclusive) 4. Value must not include commas or other non-numeric characters 5. Value must be equal to the number of claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported 6. Mandatory
1. Value must be 1 character 2. Value must be in Forced Claim Indicator List (VVL) 3. Conditional

1. Value must be 1 character 2. Value must be in Healthcare Acquired Condition Indicator List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) 3. Conditional
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1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) 3. Conditional

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code 3. Conditional 4. Value must be less than or equal to Occurrence Code End Date
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1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
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1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Conditional
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 1 character 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory
1. Value must be in Health Home Provider Indicator List (VVL) 2. Value must be 1 character 3. If there is an associated Health Home Entity Name value, then value must be "1" 4. Conditional
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period (by date of service) 4. When populated, Waiver ID (COT.002.111) must be populated 5. Conditional 6. Value must be in [06,07,08,09,10,11,12,13,14,15,16,17,18,19,20,33] when associated Program Type equals "07"
1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33] 6. Conditional

1. Value must be 30 characters or less 2. Conditional 3. When Type of Claim not in [3,C,W] then value may match (PRV.002.019) Submitting State Provider ID or 4. When Type of Claim not in [3,C,W] then value may match (PRV.005.081) Provider Identifier where the Provider Identifier Type (PRV.005.077) equals "1" 5. Must have an enrollment where the Ending Date of Service (COT.003.167) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or 6. Must have an enrollment where the Ending Date of Service (COT.003.167) may be between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080). 7. Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'.
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
1. Value must be in Provider Taxonomy List (VVL) 2. Value must be 12 characters or less 3. Conditional
1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL) 3. Conditional
1. Value must be 30 characters or less 2. Conditional
1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File

1. Value must be 12 characters or less 2. Conditional 3. Value must not contain a pipe or asterisk symbols 4. (Not Dual Eligible) if Dual Eligible Code (ELG.DE.085) value equals "00", then value must not be populated 5. Value must be populated when Crossover Indicator (COT.002.023) equals "1" and Medicare Beneficiary Identifier (COT.002.147) is not populated
1. Value must be 2 characters 2. Value must be in Place of Service Code List (VVL) 3. Conditional 4. If value is populated, then Type of Bill must not be populated
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be between 0.00 and 99999.99 2. Conditional 3. Value must be expressed as a number with 2-digit precision (e.g. 100.50)
1. Value must be 1 character 2. Value must be in Border State Indicator List (VVL) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Coinsurance Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Copayment Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Deductible Amount 3. Conditional
1. Value must be 1 character 2. Value must be in Claim Denied Indicator List (VVL) 3. If value equals "0", then Claim Status Category must equal "F2" 4. Mandatory
1. Value must be 1 character 2. Value must be in Copay Waived Indicator List (VVL) 3. Situational
1. Value must not contain a pipe or asterisk symbols 2. Value must 50 characters or less 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Situational
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Coinsurance Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Situational
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Copayment Amount 3. Situational
1. Value must be 10 digits 2. Value must have an associated Provider Identifier, where Provider Identifier Type (PRV.005.077) equals "2" 3. Value must exist in the NPPES NPI data file 4. Conditional

1. Conditional 2. Value must be an 11-character string 3. Character 1 must be numeric values 1 thru 9 4. Character 2 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 5. Character 3 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 6. Character 4 must be numeric values 0 thru 9 7. Character 5 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 8. Character 6 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 9. Character 7 must be numeric values 0 thru 9 10. Character 8 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 11. Character 9 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 12. Character 10 must be numeric values 0 thru 9 13. Character 11 must be numeric values 0 thru 9 14. Value must not contain a pipe or asterisk symbols
1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
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1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must not be more than 60 characters long 2. Mandatory 3. Value must not contain a pipe or asterisk symbols
1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. Value must not contain a pipe or asterisk symbols 5. There must be an Address Line 1 in order to have an Address Line 2
1. Value must not be more than 28 characters long 2. Mandatory
1. Value must not be more than 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory
1.Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
1. Value must not be more than 60 characters long 2. Conditional 3. Value must not contain a pipe or asterisk symbols

1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. There must be an Address Line 1 in order to have an Address Line 2 5. Value must not contain a pipe or asterisk symbols
1. Value must not be more than 28 characters long 2. Conditional
1. Value must not be more than 2 characters 2. Value must be in State Code list (VVL) 3. Conditional
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional
1. Value must not be more than 2 characters 2. Value must be in Provider Claim Form Code List (VVL) 3. Mandatory
1. Value must not be more than 50 characters long 2. Conditional 3. Value must be provided when corresponding Provider Claim Form Code is "Other"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 30 characters or less 2. Conditional 3. Value must not be populated when Referring Provider Number is not populated. 4. Value must not equal Referring Provider Number
1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File 5. Value must not be populated when Referring Provider NPI Number is not populated 6. Value must not equal Referring Provider NPI Number

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "COT00003"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (COT.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 3 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory 4. Value must be one or greater
1. Value must be 3 characters or less 2. If associated Line Adjustment Indicator value equals "0", then value must not be populated 3. If associated Line Adjustment Indicator value equals "1", then value is mandatory and must be provided 4. Conditional 5. When populated, value must be one or greater
1. Value must be 1 character 2. Value must be in Line Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Conditional 5. If associated Line Adjustment Number is populated, then value must be populated
1. Value must be 3 characters or less 2. Value must be in Line Adjustment Reason Code List (VVL) 3. Conditional 4. Value must be populated when the total paid amount is different from the total billed amount
1. Value must be 12 characters or less 2. Mandatory
1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) 3. Conditional 4. If value in [545,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be"F2"

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be less than or equal to associated Ending Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be less than or equal to at least one of the eligible's Enrollment End Date (ELG.021.254) values 7. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be greater than or equal to associated Beginning Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value 7. Mandatory
1. Value must be 4 characters or less 2. Value must be in Revenue Code List (VVL) 3. A Revenue Code value requires an associated Revenue Charge 4. Conditional
1. Value must be 8 characters or less 2. Value must be in Procedure Code List (VVL) 3. When populated, there must be a corresponding Procedure Code Flag 4. If associated Procedure Code Flag value indicates an CPT-4 encoding "01", then value must be a valid CPT-4 procedure code 5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code 6. If associated Procedure Code Flag List (VVL) value indicates an HCPCS encoding "06", then value must be a valid HCPCS code 7. Conditional

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be on or before associated Discharge Date value 3. Value must be provided with an associated Procedure Code value 4. Value must be on or after associated Beginning Date of Service value 5. Value must be on or before associated Eligible Date of Death value 6. Value must be not be populated when associated Procedure Code is not populated 7. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. When populated, there must be a corresponding Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional 4. Value should not be populated or should be equal to zero, when associated Claim Line Status is in [542,585,654]\
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Type of Claim value in [3,C,W], then value is mandatory and must be provided 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0", then the value must not be populated 4. Conditional 5. If value is populated, Crossover Indicator must be equal to "1"
1. Value may include up to 8 digits to the left of the decimal point, and 3 digits to the right e.g. 12345678.999 2. Mandatory

1. Value may include up to 8 digits to the left of the decimal point, and 3 digits to the right e.g. 12345678.999 2. Conditional
1. Value must be 3 characters. 2. Mandatory 3. Value must be in Type of Service OT List (VVL) 4. When value is not in [025,085], Sex (ELG.002.023) equals "M"
1. Value must be 1 character 2. Value must be in HCBS Service Code List (VVL) 3. If value is in [1-7], then HCBS Taxonomy must be populated 4. Conditional

1. Value must be 5 characters or less 2. Value must be in HCBS Taxonomy Code List (VVL) 3. Conditional
1. Value must be 30 characters or less 2. Conditional 3. When Type of Claim not in [3,C,W], then value may match (PRV.005.081) Provider Identifier or 4. When Type of Claim not in [3,C,W], then value may match (PRV.002.019) Submitting State Provider ID
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Conditional 4. If Type of Claim (COT.002.037) not in [3,C,W], then value must match Provider Identifier (PRV.005.081) 5. Value must exist in the NPPES NPI data file
1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 3. Conditional

1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL). 3. Conditional
1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL) 3. Conditional
1. Value must be 3 characters 2. Value must be in Other TPL Collection List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Tooth Designation System List (VVL) 3. Value must not contain a pipe symbol 4. Conditional
1. Value must be 2 characters or less 2. Value must be in Tooth Number List (VVL) 3. If Tooth Designation System (COT.003.195) is "JP" value must be found in [1..32][51-82][A..T]or [AS..KS] 4. If Tooth Designation System (COT.003.195) is "JO" value must have 1 digit before and after the decimal (N.N) 5. If Tooth Designation System (COT.003.195) is "JO" value must be a first digit of 1-4 and the decimal must be between 1-8 6. Conditional 7. When value is in [A-T], the difference between Ending Date of Service (COT.002.034) and Date of Birth (COT.002.108) is less than 15 years
1. Value must be 2 characters 2. Value must be in Tooth Quad Code List (VVL) 3. Conditional 4. When populated, associated type of service value must be in [013,029,035]
1. Value must be 1 character 2. Value must be in Tooth Surface Code List (VVL) 3. Conditional 4. When populated, associated type of service value must be in [013,029,035]
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. Conditional

1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Conditional
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Conditional
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional

1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. (Federal Funding under Title XXI) if value equals "02", then the eligible's CHIP Code (ELG.003.054) must be in [2,3] 4. (Federal Funding under Title XIX) if value equals "01" then the eligible's CHIP Code (ELG.003.054) must be "1" 5. Conditional 6. If Type of Claim is in [1,A,U] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 12 digits or less 2. Value must be a valid National Drug Code 3. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (COT.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. Value must be 3 characters 2. Value must be in Self Direction Type List (VVL) 3. Mandatory
1. Value must be 18 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional

1. Value must be 2 characters 2. Value must be in NDC Unit of Measure List (VVL) 3. Conditional
1. Value may include up to 9 digits to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789 2. Conditional
1. Value must be 1 character 2. Value must be in the IHS Service Indicator List (VVL) 3. Mandatory
1. Value must be numeric 2. Value must be 2 digits or less 3. Value must be between 1 and 12 4. Mandatory
1. Value must be numeric 2. Value must not be more than 2 digits long 3. Value must be between 1 and 12 4. Conditional
1. Value must be numeric 2. Value must not be more than 2 digits long 3. Value must be between 1 and 12 4. Conditional
1. Value must be numeric 2. Value must not be more than 2 digits long 3. Value must be between 1 and 12 4. Conditional
1. Value must not be more than 76 characters long 2. Conditional
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Conditional 4. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Conditional 6. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0

1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Conditional 11. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated
1.Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
1. Value must not be more than 60 characters long 2. Conditional 3. Value must not contain a pipe or asterisk symbols
1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. There must be an Address Line 1 in order to have an Address Line 2 5. Value must not contain a pipe or asterisk symbols
1. Value must not be more than 28 characters long 2. Conditional

1. Value must not be more than 2 characters 2. Value must be in State Code list (VVL) 3. Conditional
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional
1. Value must not be more than 2 characters 2. Value must be in Place of Service Code List (VVL) 3. Conditional 4. if value is populated, then Revenue Code must be null
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 30 characters or less 2. Conditional
1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File
1. Value must be 30 characters or less 2. Conditional

1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File 5. Value must not be populated when Referring Provider NPI Number is not populated. 6. Value must not equal Referring Provider NPI Number
1. Value must be 30 characters or less 2. Conditional
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "COT00004"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (COT.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory

1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686" 7. Value must match the adjustment indicator in the header (COT.002.025)
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (COT.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. Value must be 1 character 2. Value must be in Diagnosis Type Code List (VVL) 3. Value must be in [P,A,E,O] 4. Mandatory
1. Value must be in [01-24] 2. Mandatory
1. Value must be 1 character 2. Value must be in Diagnosis Code Flag List (VVL) 3. Mandatory

1. Value must be a minimum of 3 characters 2. If associated Diagnosis Code Flag value equals "1" (ICD-9), then value must be in ICD-9 Diagnosis Code List (VVL) 3. If associated Diagnosis Code Flag value equals "2" (ICD-10), then value must be in ICD-10 Diagnosis Code List (VVL) 4. Value must not contain a decimal point 5. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CRX00001"
1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
1. Value must be 1 character 2. Value must be in Subcaptitation Indicator List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) 3. Mandatory
1. Value must be 9 characters or less 2. Mandatory
1. Value must equal "CLAIM-RX" 2. Mandatory
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created 3. Value must be before associated End of Time Period 4. Mandatory 5. Value of the CC component must be "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be equal to or earlier than associated Date File Created 4. Value must be equal to or after associated Start of Time Period 5. Mandatory
1. Value must be 1 character 2. For production files, value must be equal to "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be a positive integer 3. Value must be between 0:99999999999 (inclusive) 4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
1. Value must be 4 characters or less 2. Value must between 1 and 9999 3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) 4. Value must not contain a pipe symbol 5. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CRX00002"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CRX.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 12 characters or less 2. Mandatory
1. Value must be 20 characters or less 2. Mandatory 3. The Prescription Fill Date (CRX.002.085) on the claim must fall between Enrollment Timespan Effective Date (ELG.021.253) and Enrollment Timespan End Date (ELG.021.253)
1. Value must be 1 character 2. Value must be in Crossover Indicator List (VVL) 3. If Crossover Indicator value equals "1", then associated Dual Eligible Code (ELG.005.085) value must be in [01,02,04,08,09,10] for the same time period (by date of service) 4. Mandatory

1. Value must be 1 character 2. Value must be in 1115A Demonstration Indicator List (VVL) 3. Conditional 4. When value equals "0", is invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.233) must equal "0", is invalid or not populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686"
1. Value must be 3 characters or less 2. Value must be in Adjustment Reason Code List (VVL) 3. Conditional 4. Value must be populated when the total paid amount is different from the total billed amount
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CIP.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Total Medicaid Paid Amount 3. Mandatory
1. Value must be 1 character 2. Value must be in Type of Claim List (VVL) 3. Mandatory
1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) 3. Conditional 4. If value in [542,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be "F2"
1. Value must be 3 characters or less 2. Value must be in Claim Status Category List (VVL) 3. (Denied Claim) if associated Claim Denied Indicator indicates the claim was denied, then value must be "F2" 4. (Denied Claim) if associated Claim Status is in [542,585,654], then value must be "F2" 5. Mandatory

1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional
1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique
1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 1 (CRX.002.035) is not populated

1. Value must be in Claim Payment Remittance Code List (VVL) 2. Value must be 5 characters or less 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 2 (CRX.002.036) is not populated
1. Value must be in Claim Payment Remittance Code List (VVL) 2. Value must be 5 characters or less 3. Conditional 4. When more than one occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when Remittance Advice Remark Code 3 (CIP.002.110) is not populated
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must equal the sum of all Billed Amount instances for the associated claim 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. When populated and Payment Level Indicator equals "2", then value must equal the sum of all claim line Allowed Amount values 4. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Must have an associated Medicaid Paid Date 4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount 5. When Payment Level Indicator equals "2", value must equal the sum of line level Medicaid Paid Amounts. 6. Conditional 7. Value must be populated, when Type of Claim is in [1,A] 8. Value must not be populated or equal to "0.00" when associated Claim Status is in [542,585,654] 9. Value must not be greater than Total Allowed Amount (CRX.002.040)
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0" (not a crossover claim), then value should not be populated 4. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in [01,02,03,04,05,06,08,09,10], then value is mandatory and must be provided 5. Conditional 6. When populated, value must be less than or equal to Total Billed Amount
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0" (not a crossover claim), then value should not be populated. 4. Conditional 5. If associated Medicare Combined Deductible Indicator equals "1", then value must not be populated 6. When populated, value must be less than or equal to Total Billed Amount
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than associated Total Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount) 4. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 1 character 2. Value must be in Other Insurance Indicator List (VVL) 3. Conditional
1. Value must be in Other TPL Collection List (VVL) 2. Value must be 3 characters 3. Mandatory
1. Value must be 1 character 2. Value must be in Fixed Payment Indicator List (VVL) 3. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. If Type of Claim is not in [3,C,W], then value must be populated 4. Conditional
1. Value must be 2 characters 2. Value must be in Funding Source Non-Federal Share List (VVL) 3. If Type of Claim is in [3,C,W], then value must be populated 4. Conditional
1. Value must be 2 characters 2. Value must be in Program Type List (VVL) 3. Mandatory 4. (Community First Choice) If value equals "11", then State Plan Option Type (ELG.011.163) must equal "01" for the same time period 5. If value equals "13", then State Plan Option Type (ELG.011.163) must equal "02" for the same time period

1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional 4. Value must match Managed Care Plan ID (ELG.014.192) 5. Value must match State Plan ID Number (MCR.002.019) 6. Value should be populated when Type of Claim (CRX.002.029) is in [3,C,W] 7. When Type of Claim (CRX.002.029) in [3,C,W] value must have a Managed Care Enrollment (ELG.014) for the beneficiary where the Prescription Fill Date (CRX.002.085) occurs between the managed care plan enrollment eff/end dates (ELG.014.197/198) 8. When Type of Claim (CRX.002.029) in [3,C,W] value must have a Managed Care Main Record (MCR.002) for the plan where the Prescription Fill Date (CRX.002.085) occurs between the managed care contract eff/end dates (MCR.002.020/021)
1. Value must be 1 character 2. Value must be in Payment Level Indicator List (VVL) 3. Mandatory

1. Value must be 2 characters 2. Value must be in Medicare Reimbursement Type List (VVL) 3. Value is mandatory and must be provided, when Crossover Indicator is equal to "1" (Crossover Claim) 4. Conditional
1. Value must be 4 characters or less 2. Value must be a positive integer 3. Value must be between 0000:9999 (inclusive) 4. Value must not include commas or other non-numeric characters 5. Value must be equal to the number of claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported 6. Mandatory
1. Value must be 1 character 2. Value must be in Forced Claim Indicator List (VVL) 3. Conditional
1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Conditional
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 1 character 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory
1. Value must be in Health Home Provider Indicator List (VVL) 2. Value must be 1 character 3. If there is an associated Health Home Entity Name value, then value must be "1" 4. Conditional

1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period (by date of service) 4. Value must have a corresponding value in Waiver ID (CRX.002.069) 5. Conditional 6. Value must be in [06,07,08,09,10,11,12,13,14,15,16,17,18,19,20,33] when associated Program Type equals "07"
1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33] 6. Conditional
1. Value must be 30 characters or less 2. Conditional 3. When Type of Claim not in [3,C,W] then value may match (PRV.002.019) Submitting State Provider ID or 4. When Type of Claim not in [3,C,W] then value may match (PRV.005.081) Provider Identifier where the Provider Identifier Type (PRV.005.077) equals "1" 5. Discharge Date (CIP.002.096) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or 6. Discharge Date (CIP.002.096) may be between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 3. Conditional

1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL) 3. Conditional
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Mandatory 4. Value must exist in the NPPES NPI data file 5. NPPES Entity Type Code associate with this NPI must equal ‘1’ (Individual)
1. Value must be 12 characters or less 2. Conditional 3. Value must not contain a pipe or asterisk symbols 4. (Not Dual Eligible) if Dual Eligible Code (ELG.DE.085) value equals "00", then value must not be populated 5. Value must be populated when Crossover Indicator (CRX.002.023) equals "1" and Medicare Beneficiary Identifier (CRX.002.105) is not populated
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 1 character 2. Value must be in Border State Indicator List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be on or after associated eligible party's Date of Birth (ELG.002.024) 3. Value must be on or before associated Prescription Fill Date (CRX.002.085) 4. Value must be on or before associated Adjudication Date (CRX.002.027) 5. Value must be on or before associated eligible party's Date of Death (ELG.002.025) 6. Mandatory 7. Value should be on or before End of Time Period (CRX.001.010)

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be on or before associated End of Time Period (CRX.001.010) 3. Value must be on or after associated Start of Time Period (CRX.001.009) 4. Value must be on or after associated Date Prescribed (CRX.002.084) 5. Value must be on or after associated eligible party's Date of Birth (ELG.002.024) 6. Value must be on or before associated eligible party's Date of Death (ELG.002.025) 7. Value must be populated when Adjustment Indicator (CRX.002.025) does not equal "1" 8. Mandatory
1. Value must be 1 character 2. Value must be in Compound Drug Indicator List (VVL) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Coinsurance Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Copayment Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Deductible Amount 3. Conditional
1. Value must be 1 character 2. Value must be in Claim Denied Indicator List (VVL) 3. If value equals "0", then Claim Status Category must equal "F2" 4. Mandatory

1. Value must be 1 character 2. Value must be in Copay Waived Indicator List (VVL) 3. Situational
1. Value must not contain a pipe or asterisk symbols 2. Value must 50 characters or less 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Situational
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Coinsurance Amount 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Situational
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Copayment Amount 3. Situational
1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type (PRV.005.007) equal to '2' 3. When Type of Claim not in [3,C,W], then value must match Provider Identifier (PRV.005.081) 4. Mandatory 5. Value must exist in the NPPES NPI data file 6. NPPES Entity Type Code associate with this NPI must equal "1" (Individual)
1. Value must be 10 digits 2. Value must have an associated Provider Identifier, where Provider Identifier Type (PRV.005.077) equals "2" 3. Value must exist in the NPPES NPI data file 4. Conditional

1. Conditional 2. Value must be an 11-character string 3. Character 1 must be numeric values 1 thru 9 4. Character 2 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 5. Character 3 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 6. Character 4 must be numeric values 0 thru 9 7. Character 5 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 8. Character 6 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 9. Character 7 must be numeric values 0 thru 9 10. Character 8 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 11. Character 9 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 12. Character 10 must be numeric values 0 thru 9 13. Character 11 must be numeric values 0 thru 9 14. Value must not contain a pipe or asterisk symbols
1. Value must be 30 characters or less 2. When Type of Claim not in [3,C,W] then value may match Submitting State Provider ID (PRV.002.019) or 3. When Type of Claim not in[3,C,W] then value may match Provider Identifier (PRV.005.081) where the Provider Identifier Type (PRV.005.077) equals "1" 4. Mandatory
1. Value must be 1 character 2. Value must be in Medicare Combined Deductible Indicator List (VVL) 3. If value equals "1", then Total Medicare Coinsurance amount must not be populated 4. If value equals "0", then Crossover Indicator must equals "0" 5. If value equals "1", then Crossover Indicator must equals "1" 6. Conditional
1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be one digit 2. Value must be in Prescription Origin Code List (VVL) 3. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must not be more than 2 characters 2. Value must be in Provider Claim Form Code List (VVL) 3. Mandatory
1. Value must not be more than 50 characters long 2. Conditional 3. Value must be provided when corresponding Provider Claim Form Code is "Other"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CRX00003"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CRX.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 3 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory 4. Value must be one or greater
1. Value must be 3 characters or less 2. If associated Line Adjustment Indicator value equals "0", then value must not be populated 3. If associated Line Adjustment Indicator value equals "1", then value is mandatory and must be provided 4. Conditional 5. When populated, value must be one or greater
1. Value must be 1 character 2. Value must be in Line Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Conditional 5. If associated Line Adjustment Number is populated, then value must be populated
1. Value must be 3 characters or less 2. Value must be in Line Adjustment Reason Code List (VVL) 3. Conditional 4. Value must be populated when the total paid amount is different from the total billed amount
1. Value must be 12 characters or less 2. Mandatory
1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) 3. Conditional 4. If value in [545,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be"F2"
1. Value must be 12 digits or less 2. Value must be a valid National Drug Code 3. Mandatory 4. Value must have an associated Metric Decimal Quantity (CRX.003.144) 5. Value must have an associated Unit of Measure (CRX.003.133)

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional 4. Value should not be populated or should be equal to zero, when associated Claim Line Status is in [542,585,654]
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Type of Claim value in [3,C,W], then value is mandatory and must be provided 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional 4. Value should not be populated if associated Crossover Indicator value equals "0" (not a crossover claim) 5. If value is greater than "0", then Crossover Indicator must be "1"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Medicare Combined Deductible Indicator equals "1", then value must not be populated (or must be 99998) 4. Value must not be populated if Medicare Deductible Amount is not populated 5. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value equals "0", then the value must not be populated 4. Conditional 5. If value is populated, Crossover Indicator must be equal to "1"

1. Value may include up to 9 digits to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789 2. Conditional
1. Value may include up to 9 digits to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789 2. Mandatory
1. Value must be 2 characters 2. Value must be in Unit of Measure List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Mandatory 3. Value must be in Type of Service RX List (VVL)
1. Value must be 1 character 2. Value must be in HCBS Service Code List (VVL) 3. If value is in [1-7], then HCBS Taxonomy must be populated 4. Conditional

1. Value must be 5 characters or less 2. Value must be in HCBS Taxonomy Code List (VVL) 3. Conditional
1. Value must be 3 characters 2. Value must be in Other TPL Collection List (VVL) 3. Mandatory
1. Value must be 5 digits or less 2. Mandatory 3. Value should be between -365 and 365
1. Value must be 2 characters 2. Value must be in New Refill Indicator List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in Brand Generic Indicator List (VVL) 3. Mandatory

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value may include up to 6 digits to the left of the decimal point, and 2 digits to the right e.g. 123456.78 4. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Mandatory
1. Value must be 6 characters or less 2. Characters 1 and 2 (2-character string) must be in Drug Utilization Reason for Service Code List (VVL) 3. Characters 3 and 4 (2-character string) must be in Drug Utilization Professional Service Code List (VVL) 4. Characters 5 and 6 (2-character string) must be in Drug Utilization Result of Service Code List (VVL) 5. Mandatory
1. Value must be numeric 2. Value may include up to 7 digits to the left of the decimal point, and 3 digits to the right, e.g. 1234567.890 3. Value must be populated when Compound Drug Indicator (CRX.002.086) equals "1" 4. Conditional
1. Value must be 2 characters 2. Value must be in Compound Dosage Form List (VVL) 3. Conditional
1. Value must be 1 character 2. Value must be in Rebate Eligible Indicator List (VVL) 3. Conditional

1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. (Federal Funding under Title XXI) if value equals "02", then the eligible's CHIP Code (ELG.003.054) must be in [2,3] 4. (Federal Funding under Title XIX) if value equals "01" then the eligible's CHIP Code (ELG.003.054) must be "1" 5. Conditional 6. If Type of Claim is in [1,A,U] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CIP.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. Value must be 3 characters 2. Value must be in Self Direction Type List (VVL) 3. Mandatory
1. Value must be 18 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 1 character 2. Value must be in the IHS Service Indicator List (VVL) 3. Mandatory
1. Value must not be more than 76 characters long 2. Conditional
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Conditional 4. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Conditional 6. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0

1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Conditional 11. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated
1. Value must not be more than 6 characters 2. Value must be in Procedure Code List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional

1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CRX00004"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CRX.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. If value is in [4,1] then Adjustment ICN must be populated 7. Value must equal "1", when associated Claim Status equals "686" 8. Value must match the adjustment indicator in the header (CRX.002.025)
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CRX.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
1. Value must be 1 character 2. Value must be in Diagnosis Type Code List (VVL) 3. Value must be "D" 4. Mandatory
1. Value must be in [01-24] 2. Mandatory
1. Value must be 1 character 2. Value must be in Diagnosis Code Flag List (VVL) 3. Mandatory

1. Value must be a minimum of 3 characters 2. If associated Diagnosis Code Flag value equals "1" (ICD-9), then value must be in ICD-9 Diagnosis Code List (VVL) 3. If associated Diagnosis Code Flag value equals "2" (ICD-10), then value must be in ICD-10 Diagnosis Code List (VVL) 4. Value must not contain a decimal point 5. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00001"
1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
1. Value must be 1 characters 2. Value must be in Submission Transaction Type List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) 3. Mandatory
1. Value must be 9 characters or less 2. Mandatory
1. Value must equal "ELIGIBLE" 2. Mandatory
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same for all records
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created 3. Value must be before associated End of Time Period 4. Mandatory 5. Value of the CC component must be "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be equal to or earlier than associated Date File Created 4. Value must be equal to or after associated Start of Time Period 5. Mandatory
1. Value must be 1 character 2. For production files, value must be equal to "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be a positive integer 3. Value must be between 0:99999999999 (inclusive) 4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
1. Value must be 2 characters 2. Value must be in File Submission Method List (VVL) 3. Mandatory
1. Value must be 4 characters or less 2. Value must between 1 and 9999 3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) 4. Value must not contain a pipe symbol 5. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00002"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 1 character 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 1 character 2. Value must be in Sex List (VVL) 3. (Pregnancy) if value equals "M", then associated Pregnancy Indicator (ELG.003.049) value must not equal "1" 4. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Children enrolled in the Separate CHIP prenatal program option should have a date of birth missing or a date of birth equal to the pregnant mothers date of birth 3. When Conception to Birth Indicator (ELG.005.094) does not equal "1" and Eligibility Group (ELG.005.087) does not equal "64" value must be less than or equal to associated End of Time Period value 4. Value must be less than or equal to associated Date File Created (ELG.001.008) value 5. Mandatory 6. When Conception to Birth Indicator (ELG.005.094) does not equal "1" and Eligibility Group (ELG.005.087) does not equal "64" value minus Start of Time Period (ELG.001.10) must be less than 125 years
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Conditional 3. If populated, value must be on or after individual's Date of Birth 4. Value must be less than or equal to associated Date File Created (ELG.001.008) value 5. There must never be more than one Date of Death value reported across Primary Demographic segments that have the same MSIS Identification number 6. When populated, Procedure Code Dates on a claim must be less than or equal to this value 7. When populated, Admission Date on a claim must be less than or equal to this value 8. When populated, Discharge Date on a claim must be less than or equal to this value 9. When populated, Ending Date of Service on a claim must be less than or equal to this value 10. When populated, value must be less than or equal to Enrollment End Date (ELG.021.254) 11. When populated, value minus Date of Birth (ELG.002.024) is less than or equal to 125 years
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]

1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00003"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory

1. Value must be 2 characters 2. Value must be in Marital Status List (VVL) 3. Conditional
1. If associated Marital Status (ELG.003.035) equals "14" (Other), then value is mandatory and must be provided 2. Value must be 50 characters or less 3. Value must not contain a pipe or asterisk symbol 4. Conditional
1. Value must be 9-digit number 2. For any individual, the value must be the same over all segment effective and end dates 3. (SSN State) if associated SSN Indicator (ELG.001.012) value is coded as "1", then value must equal MSIS Identification Number (ELG.002.019) value 4. Value can only be reported with one MSIS Identification Number (ELG.002.019) 5. Conditional 6. (Non-SSN State) if associated SSN Indicator (ELG.001.012) value is coded as "0", then value must not equal MSIS Identification Number (ELG.002.019)
1. Value must be 1 character 2. Value must be in SSN Verification Flag List (VVL) 3. Mandatory

1. Value must be 2 characters 2. Value must be in Income Code List (VVL) 3. Conditional
1. Value must be 1 character 2. Value must be in Veteran Indicator List (VVL) 3. Conditional 4. Value must be populated when Immigration Status (ELG.003.042) is in [1,2,3]
1. Value must be 1 character 2. Value must be in [0,1,2] 3. Value must be in Citizenship Indicator List (VVL) 4. If value equals "0", then associated Immigration Status (ELG.003.042) value must be in [1,2,3] 5. If value is coded as "1", then associated Immigration Status (ELG.003.042) value must equal "8" 6. Mandatory
1. Value must be 1 character 2. Value must be in Citizenship Verification Flag List (VVL) 3. Value must be populated when Citizenship Indicator (ELG.003.040) equals "1" (US Citizen) 4. Conditional
1. Value must be 1 character 2. Value must be in Immigration Status List (VVL) 3. If associated Citizenship Indicator (ELG.003.040) value equals "0", then value must be in [1,2,3] 4. If associated Citizenship Indicator (ELG.003.040) value equals "1", then value must equal "8" 5. Mandatory
1. Value must be 1 character 2. Value must be in Immigration Verification Flag List (VVL) 3. Conditional

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Conditional 3. If Immigration Status (ELG.003.042) equals "8" (U.S. Citizen), then value should not be populated
1. Value must be 1 character 2. Value must be in Primary Language English Proficiency Code List (VVL) 3. Conditional
1. Value must be 3 characters 2. Value must be in Primary Language Code List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Household Size List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in Pregnancy Indicator List (VVL) 3. Conditional
1. Value must be 12 characters or less 2. Conditional 3. Value must not contain a pipe or asterisk symbols 4. (Not Dual Eligible) if Dual Eligible Code (ELG.DE.085) value is "00", then value must not be populated. 5. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in [01,02,03,04,05,06,08,09,10], then value for either HICN or MBI is mandatory and must be provided

1. Conditional
2. Value must be an 11-character string
3. Character 1 must be numeric values 1 thru 9
4. Character 2 must be alphabetic values A thru Z (minus S,L,O,I,B,Z)
5. Character 3 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z)
6. Character 4 must be numeric values 0 thru 9
7. Character 5 must be alphabetic values A thru Z (minus S,L,O,I,B,Z)
8. Character 6 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z)
9. Character 7 must be numeric values 0 thru 9
10. Character 8 must be alphabetic values A thru Z (minus S,L,O,I,B,Z)
11. Character 9 must be alphabetic values A thru Z (minus S,L,O,I,B,Z)
12. Character 10 must be numeric values 0 thru 9
13. Character 11 must be numeric values 0 thru 9
14. Value must not contain a pipe or asterisk symbols
15. When Dual Eligible Code (ELG.005.085) equals "00" and End of Time Period (ELG.001.010) greater than or equal to "2015-11-01", value should not be populated
16. (Medicare Enrolled) if associated Dual Eligible Code value (ELG.005.085) is in [01,02,03,04,05,06,08,09,10], then the value for either HICN or MBI is mandatory and must be provided

1. Value must be in CHIP Code List (VVL)
2. If value is in [2,3], then associated Eligibility Group (ELG.005.087) value must be in [07,31,61,62,63,64,65,66,67,68]
3. If value equals "1", then associated Eligibility Group (ELG.005.087) value must not be in [61,62,63,64,65,66,67,68]
4. Value must be 1 character
5. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment End Date value
3. Mandatory
4. Value of the CC component must be in [19,20,99]\

1. The date must be a valid calendar date in the form "CCYYMMDD"
2. Value must be greater than or equal to associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1. Value must be between 000 and 400 inclusively 2. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Conditional 3. Value must be less than the Variable Demographic Element End Date
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00004"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory

1. Value must be 20 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Eligible Address Type List (VVL) 3. Mandatory
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. Mandatory
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 2 value(s) 3. If Address Line 2 is not populated, then value should not be populated 4. Value must not contain a pipe or asterisk symbols 5. Conditional
1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory

1. Value must be 3 characters 2. Value must be in US County Code List (VVL) 3. Mandatory
1. Value must be 10-digit number 2. Conditional
1. Value must not contain a pipe or asterisk symbol 2. Value must be 100 characters or less 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00005"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory

1. Value must be 20 characters or less 2. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe symbol 3. Mandatory
1. Value must be 2 characters 2. Value must be in Dual Eligible Code List (VVL) 3. If value equals "05", then Eligibility Group (ELG.005.087) must be "24" 4. If value equals "06", then Eligibility Group (ELG.005.087) must be "26" 5. If Dual Eligible Code (ELG.005.085) is in [01,02,03,04,05,06,08,09,10], then Primary Eligibility Group Indicator (ELG.005.086) must be "1" (Yes) 6. Mandatory 7. A partial dual eligible (values="01", "03", "05" or "06") then Restricted Benefits Code (ELG.005.097) must be "3" 8. (Not Dual Eligible) if value = "00", then associated Medicare Beneficiary Identifier (ELG.003.051) value must not be populated. 9. Value must be 2 characters 10. If value is in [08,10] then Restricted Benefits Code (ELG.005.097) must be "1" 11. If value equals "09", then Eligibility Group (ELG.005.087) and Restricted Benefits Code (ELG.005.097) must not be populated 12. If value equals "10", then CHIP Code (ELG.003.054) must be "03" (S-CHIP) and Medicare Beneficiary Identifier (ELG.003.051) must be populated 13. If value equals "01", then Eligibility Group (ELG.005.087) must be "23" 14. If value equals "03", then Eligibility Group (ELG.005.087) must be "25"

1. Value must be 1 character 2. Value must be in Primary Eligibility Group Indicator List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Eligibility Group List (VVL) 3. If value is "26", then Dual Eligible Code value must be "06" 4. Conditional 5. Value is mandatory and must be provided when associated Eligibility Determinant Effective Date value is on or after 1 January, 2014. 6. If value is in [72,73,74,75], then associated Restricted Benefits Code value must be in [1,7] and State Plan Option Type must equal "06" 7. If associated CHIP Code value equals "2", then value must be in [07,31,61] 8. If associated CHIP Code value equals "3", then value must be in [61,62,63,64,65,66,67,68] 9. If value is "23", then Dual Eligible Code value must be in [01,02] 10. If value is "25", then Dual Eligible Code value must be in [03,04] 11. If value is "24", then Dual Eligible Code value must be "05"
1. Value must be 3 characters 2. Value must be in Level of Care Status List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in SSDI Indicator List (VVL) 3. Conditional

1. Value must be 1 character 2. Value must be in SSI Indicator List (VVL) 3. Conditional 4. Value must equal "0" when SSI status (ELG.005.092) equals "000" or "003" or is not populated 5. Value must equal "1" when SSI status (ELG.005.092) equals "001" or "002"
1. Value must be 3 characters 2. Value must be in SSI State Supplement Status Code List (VVL) 3. (individual not receiving Federal SSI) If value is "001" or "002", then SSI Status (ELG.005.092) must be "001" or "002" 4. (Individual not receiving Federal SSI)If value is "001" or "002", then SSI Indicator (ELG.005.090) must be "1" 5. Value must not be populated or must be "000" when SSI Status (ELG.005.092) is not populated or is "000" 6. Conditional
1. Value must be 3 characters 2. Value must be in SSI Status List (VVL) 3. Conditional 4. When value is "001" or "002", then SSI Indicator must be "1" 5. When value is "000" or "003" or not populate, then SSI Indicator must be "0"
1. Value must be 6 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in Conception to Birth Indicator List (VVL) 3. If the value is equal to "1", then the Eligibility Group (ELG.005.087) must equal "64" 4. If the value is equal to "1", then any associated claims must indicate the Program Type equals "14" (State Plan CHIP) 5. If the value is equal to "1", then CHIP Code (ELG.003.054) must equal "3" (Individual was not Medicaid Expansion CHIP eligible, but was included in a separate title XXI CHIP Program) 6. Conditional

1. Value must be 2 characters
2. Value must be in Eligibility Change Reason List (VVL)
3. Conditional

1. Value must be 1 character
2. Value must be in Restricted Benefits Code List (VVL)
3. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value equals "05", then Eligibility Group (ELG.005.087) must be "24"
4. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value equals "06", then Eligibility Group (ELG.005.087) must be "26"
5. (Restricted Benefits) if value equals "1" and Dual Eligible Code (ELG.005.085) value equals "02", then Eligibility Group (ELG.005.087) must be "23"
6. (Restricted Benefits) if value equals "1" and Dual Eligible Code (ELG.005.085) value equals "04", then Eligibility Group (ELG.005.087) must be "25"
7. (Restricted Benefits) if value equals "3", then Dual Eligible Code (ELG.005.085) cannot be "00"
8. Mandatory
9. If value is "6" then Eligibility Group(ELG.DE.087) must be in [35,70]
10. If value is in [1,7] then Eligibility Group (EGL.DE.087) must be in [72,73,74,75] and State Plan Option Type (ELG.DE.163) must equal "06"
11. (Restricted Pregnancy-Related) if value equals "4", then associated Sex (ELG.002.023) value must be "F"
12. (Non-Citizen) if value equals "2", then associated Citizenship Indicator (ELG.003.040) value must not be equal to "1"
13. If value is "D", there must be a corresponding MFP enrollment segment (ELG00010) with Effective and End dates that are within the timespan of this segment
14. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value equals "01", then Eligibility Group (ELG.005.087) must be "23"
15. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value equals "03", then Eligibility Group (ELG.005.087) must be "25"
16. (Restricted Benefits) if value is "G", then Dual Eligible Code (ELG.005.085) must be in [01,03,06]

1. Value must be 1 character 2. Value must be in TANF Cash Code List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Conditional 3. Value must be greater than the Eligibility Determinant Effective Date
1. Value must be 3 characters or less 2. Value must be in Eligibility Extension Code List (VVL) 3. Conditional
1. Value must be 50 characters or less 2. Conditional 3. If Eligibility Extension Code is "Other", then value must be populated
1. Value must be 3 characters 2. Value must be in Continuous Eligibility Code List (VVL) 3. Conditional
1. Value must not be more than 50 characters long 2. Conditional 3. If Continuous Eligibility Code is "Other", then value must be populated
1. Value must be 2 characters 2. Value must be in Income Standard Code List (VVL) 3. Conditional
1. Value must be 50 characters or less 2. Conditional 3. If Income Standard Code equals "Other", then value must be populated
1. Value must be 100 characters or less 2. Value must be populated when Eligibility Termination Reason equals "22" (Other) 3. Value must not be populated when Eligibility Termination Reason does not equal "22" (Other) 4. Conditional

1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00006"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 100 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must not contain a pipe or asterisk symbols 2. Value must 100 characters or less 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00007"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 100 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must not contain a pipe or asterisk symbols 2. Value must 100 characters or less 3. Mandatory

1. Value must be 30 characters or less 2. Value must match Provider Identifier (PRV.005.081) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00008"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory

1. Value must be 20 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in Health Home Chronic Condition List (VVL) 3. If value equals "H", associated Health Home Chronic Condition Other Explanation must be provided 4. Mandatory
1. Value must be 50 characters or less 2. If associated Health Home Chronic Condition (ELG.008.130) value equals "H", the value must be populated 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00009"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 3 characters 2. Conditional 3. Value must be in Type of Service List (VVL)
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00010"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in MFP Lives with Family List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in MFP Qualified Institution List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in MFP Qualified Residence List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in MFP Reason Participation Ended List (VVL) 3. Conditional 4. Value must not be populated when Enrollment End Date equals "9999-12-31" 5. Value must be populated when Enrollment End Date does not equal "9999-12-31"

1. Value must be 2 characters 2. Value must be in MFP Reinstitutionalized Reason List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00011"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory

1. Value must be 2 characters 2. Value must be in State Plan Option Type List (VVL) 3. If associated Eligibility Group (ELG.005.087) value is in [72,73,74, 75], and Restricted Benefits Code (ELG.DE.097) is in [1,7], then value must be "06" 4. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00012"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory

1. Value must be 20 characters or less 2. Mandatory
1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Value must have a corresponding value in Waiver Type (ELG.012.173) 7. Mandatory
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID (ELG.012.172) 4. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Mandatory 2. Value must be 8 characters 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00013"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in LTSS Level of Care List (VVL) 3. Mandatory
1. Value must be 30 characters or less 2. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00014"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Value reported must match the value reported on State Plan Identification Number (MCR.002.019) 4. Mandatory

1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. Mandatory 4. Value must equal the Managed Care Plan Type (MCR.002.024) associated with the State Plan Identification Number (MCR.002.018)
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00015"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory

1. Value must be 20 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in Ethnicity Code List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 25 characters or less 2. If Ethnicity Code (ELG.015.204) equals "4" (Other), then value must be populated 3. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00016"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory

1. Value must be 3 characters
2. Value must be in Race List (VVL)
3. Mandatory

1. Value must be 25 characters or less
2. If associated Race (ELG.016.213) value is in [010,015,018], then value must be populated
3. Value must not contain a pipe or asterisk symbol
4. Conditional

1. Value must be 1 character 2. Value must be in American Indian Alaskan Native Indicator List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00017"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Disability Type Code List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00018"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in 1115A Demonstration Indicator List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00020"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 3 characters 2. Value must be in HCBS Chronic Condition Non Health Home Code List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00021"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be in Enrollment Type List (VVL) 2. Value must be 1 character 3. If value equals "1", then associated CHIP Code (ELG.003.054) value must be in [1, 2] 4. If value equals "2", then associated CHIP Code (ELG.003.054) value must be "3" 5. A person enrolled in Medicaid/CHIP must have a primary eligibility group classification for any given day of enrollment. (There may or may not be a secondary eligibility group classification for that same day.) 6. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00022"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in Eligible Identifier Type List (VVL) 3. Mandatory
1. Value must be 18 characters or less 2. Situational
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]

1. Value must be 20 characters or less 2. Mandatory 3. Must not contain a pipe symbol
1. Value must be 10 characters or less 2. Value must be in Reason for Change List (VVL) 3. Conditional 4. (Old MSIS Identification Number) value must be populated when Eligible Identifier Type (ELG.022.261) equals "2"
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00023"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in Sex Assigned at Birth List (VVL) 3. Conditional
1. Value must be 100 characters or less 2. Conditional 3. If Sex Assigned at Birth equals "5" (Other), then value must be populated

1. Value must be 1 character 2. Value must be in Gender Identity List (VVL) 3. Conditional
1. Value must be 100 characters or less 2. Conditional 3. If Gender Identity equals "7" (Other), then value must be populated
1. Value must be 1 character 2. Value must be in Sexual Orientation List (VVL) 3. Conditional
1. Value must be 100 characters or less 2. Conditional 3. If Sex Orientation equals "6" (Other), then value must be populated
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00001"
1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
1. Value must be 1 character 2. Value must be in Submission Transaction Type List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) 3. Mandatory
1. Value must be 9 characters or less 2. Mandatory
1. Value must equal "FINTRANS" 2. Mandatory
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created 3. Value must be before associated End of Time Period 4. Mandatory 5. Value of the CC component must be "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be equal to or earlier than associated Date File Created 4. Value must be equal to or after associated Start of Time Period 5. Mandatory

1. Value must be 1 character 2. Value must be in File Status Indicator List (VVL) 3. For production files, value must be equal to "P" 4. Mandatory
1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be a positive integer 3. Value must be between 0:99999999999 (inclusive) 4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
1. Value must be 4 characters or less 2. Value must between 1 and 9999 3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) 4. Value must not contain a pipe symbol 5. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00002"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional

1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)

1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payer ID Type equals "02", then value must be populated 4. If Payer ID Type does not equal "02", then value must not be populated 5. Conditional
1. Value must be 100 characters or less 2. Value must be populated when Payer MCR Plan Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional

1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
1. Value must be 100 characters or less 2. Conditional 3. If Subcapitation Indicator equals "01", then value must be populated
1. Value must be 20 characters or less 2. Mandatory 3. Value must match MSIS Identification Number (ELG.021.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Capitation Period Start Date is equal to or greater than Enrollment Start Date and Capitation Period End Date is less than or equal to Enrollment End Date
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Capitation Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Capitation Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory

1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. If Subcapitation Indicator equals "01", then value must be populated 4. Conditional
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. If Subcapitation Indicator equals "01", then value must be populated 6. Conditional
1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. If Subcapitation Indicator equals "01", then value must be populated 11. Conditional 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated

1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period 5. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. If Subcapitation Indicator equals "01", then value must be populated 4. Conditional
1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share List (VVL) 3. If Subcapitation Indicator equals "01", then value must be populated 4. Conditional
1. Value must be 1 character 2. Value must be in State Directed Payment Indicator List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Conditional

1. Value must be 1 character 2. Value must be in Subcaptitation Indicator List (VVL) 3. Mandatory
1. Value must be 50 characters or less 2. If Subcapitation Indicator equals "01", then value must be populated 3. Conditional
1. Value must be 100 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. If Subcapitation Indicator equals "01", then value must be populated 4. Conditional
1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
1. Value must be 500 characters or less 2. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00003"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory

1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. Value must be 30 characters or less 2. Mandatory

1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007)
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements

1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must not contain a pipe or asterisk symbol 2. Value must be 20 characters or less 3. Conditional
1. Value must be 20 characters or less 2. Mandatory 3. Value must match MSIS Identification Number (ELG.021.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Payment Period Start Date is equal to or greater than Enrollment Start Date and Payment Period End Date is less than or equal to Enrollment End Date.
1. Value must be 20 characters or less 2. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Coverage Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Premium Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory

1. Value must be 50 characters or less
2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL)
3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL)
4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL)
5. Mandatory

1. Value must be 5 characters or less
2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL)
3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL)
4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL)
5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL)
6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL)
7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL)
8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL)
9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL)
10. Mandatory

1. Value must be 20 characters or less
2. Value must be associated with a populated Waiver Type
3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30]
4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position
5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Conditional

1. Value must be 2 characters
2. Value must be in Waiver Type List (VVL)
3. Value must have a corresponding value in Waiver ID
4. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period
5. Conditional

1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
1. Value must be 500 characters or less 2. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00004"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be equal to "20" 3. Mandatory
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional

1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007)
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional

1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must not contain a pipe or asterisk symbol 2. Value must be 20 characters or less 3. Conditional
1. Value must be 20 characters or less 2. Conditional 3. Value must match MSIS Identification Number (ELG.021.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Premium Period Start Date is equal to or greater than Enrollment Start Date and Premium Period End Date is less than or equal to Enrollment End Date

1. Value must be 9-digit number 2. Conditional
1. Value must be 20 characters or less 2. Conditional
1. Value must be 16 characters or less 2. Value must not contain a pipe symbol 3. Conditional
1. Value must be 2 characters 2. Value must be in Policy Owner Code List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Premium Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Premium Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. If Policy Owner Code equals "01", then value must be populated 4. Conditional
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. If Policy Owner Code equals "01", then value must be populated 4. Conditional
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. If Policy Owner Code equals "01", then value must be populated 6. Conditional

1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. If Policy Owner Code equals "01", then value must be populated 11. Conditional 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated
1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period 5. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. If Policy Owner Code equals "01", then value must be populated 4. Conditional

1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share List (VVL) 3. If Policy Owner Code equals "01", then value must be populated 4. Mandatory
1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. If Policy Owner Code equals "01", then value must be populated 4. Conditional
1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
1. Value must be 500 characters or less 2. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00005"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. Value must be 30 characters or less 2. Value must equal Submitting State (FTX.001.007) 3. Mandatory

1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007)
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Value must equal MSIS Identification Number (ELG.002.019) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional
1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional

1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
1. Value must be 100 characters or less 2. Conditional 3. If Offset Transaction Type equals "1", value must be populated
1. Value must not contain a pipe or asterisk symbol 2. Value must be 20 characters or less 3. Conditional
1. Value must be 20 characters or less 2. Mandatory 3. Value must match MSIS Identification Number (ELG.021.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Coverage Period Start Date is equal to or greater than Enrollment Start Date and Coverage Period End Date is less than or equal to Enrollment End Date
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Cost Settlement Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Cost Settlement Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory
1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory

1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in Offset Transaction Type List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Conditional

1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
1. Value must be 500 characters or less 2. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00005"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory

1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional
1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
1. Value must be 100 characters or less 2. Conditional 3. If Payee ID Type is in [02,03], then value must be populated

1. Value must be 20 characters or less 2. Conditional 3. When populated, value must match MSIS Identification Number (ELG.002.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Performance Period Start Date is equal to or greater than Enrollment Start Date and Performance Period End Date is less than or equal to Enrollment End Date
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Performance Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Performance Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory

1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory
1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in State Directed Payment Indicator List (VVL) 3. Mandatory

1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Value Based Payment Model Type List (VVL) 3. Conditional
1. Value must be 50 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
1. Value must be 500 characters or less 2. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00007"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional

1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory

1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional
1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
1. Value must be 100 characters or less 2. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Payment Period End Date 3. Mandatory 4. Value of the CC component must be equal to "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Payment Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. Value must be 2 characters 2. Value must be in Payment Period Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payment Period Type equals "95" 3. Conditional

1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory
1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory
1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional

1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Conditional
1. Value must be 50 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
1. Value must be 500 characters or less 2. Conditional

1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00008"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"

1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory

1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional
1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Cost Settlement Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Cost Settlement Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory
1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory

1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory

1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
1. Value must be 500 characters or less 2. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00009"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory

1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional
1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Coverage Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Wrap Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory
1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory

1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory

1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
1. Value must be 500 characters or less 2. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00095"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payer ID Type equals "02", then value must be populated 4. If Payer ID Type does not equal "02", then value must not be populated 5. Conditional
1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory

1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional
1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
1. Value must be 100 characters or less 2. Conditional
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional

1. Value must be 20 characters or less 2. Conditional 3. When populated, value must match MSIS Identification Number (ELG.002.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Payment Period Start Date is equal to or greater than Enrollment Start Date and Period End Date is less than or equal to Enrollment End Date
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Payment Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value must be after or the same as the associated Payment Period Start Date 4. Value of the CC component must be equal to "20"
1. Value must be 2 characters 2. Value must be in Payment Period Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. Value must be populated when Payment Period Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Transaction Type List (VVL) 3. Conditional
1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory

1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory
1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory
1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory

1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in State Directed Payment Indicator List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
1. Value must be 15 characters or less 2. Conditional
1. Value must be 50 characters or less 2. Conditional
1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
1. Value must be 500 characters or less 2. Conditional
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00001"
1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
1. Value must be 1 character 2. Value must be in Subcaptitation Indicator List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) 3. Mandatory
1. Value must be 9 characters or less 2. Mandatory
1. Value must equal "MNGDCARE" 2. Mandatory
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same for all records
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created 3. Value must be before associated End of Time Period 4. Mandatory 5. Value of the CC component must be "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be equal to or earlier than associated Date File Created 4. Value must be equal to or after associated Start of Time Period 5. Mandatory

1. Value must be 1 character 2. For production files, value must be equal to "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
1. Value must be 11 digits or less 2. Value must be a positive integer 3. Value must be between 0:99999999999 (inclusive) 4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
1. Value must be 2 characters 2. Value must be in File Submission Method List (VVL) 3. Mandatory
1. Value must be 4 characters or less 2. Value must between 1 and 9999 3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) 4. Value must not contain a pipe symbol 5. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00002"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value must occur before Managed Care Contract End Date (MCR.002.021)

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory
1. Value must be 55 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Mandatory
1. Value must be 1 character 2. Value must be in Managed Care Program List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Reimbursement Arrangement List (VVL) 3. Mandatory
1. Value must be 2 characters 2. Value must be in Managed Care Profit Status List (VVL) 3. Mandatory

1. Value must be 1 character 2. Value must be in Core Based Statistical Area Code List (VVL) 3. Mandatory
1. Value must be between 000 and 100 inclusively 2. Mandatory
1. Value must be 1 character 2. Value must be in Managed Care Service Area List (VVL) 3. Mandatory 4. When value equals "2", the associated Managed Care Service Area Name (MCR.004.058) value must be a valid US County Code
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00003"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 15 characters or less 2. Value must not contain a pipe symbol 3. Each managed care entity's locations must have a unique identifier 4. Value must be populated if associated Managed Care Address Type (MCR.003.041) equals 3 (Managed care entity's service location address) 5. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 1 character 2. Value must be in Managed Care Address Type List (VVL) 3. Mandatory

1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. Mandatory
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 2 value(s) 3. If Address Line 2 is not populated, then value should not be populated 4. Value must not contain a pipe or asterisk symbols 5. Conditional
1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must not be more than 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in US County Code List (VVL) 3. Mandatory
1. Value must be 10-digit number 2. Situational
1. Must contain the "@" symbol 2. May contain uppercase and lowercase Latin letters A to Z and a to z 3. May contain digits 0-9 4. Must contain a dot "." that is not the first or last character and provided that it does not appear consecutively 5. Value must be 60 characters or less 6. Situational
1. Value must be 10-digit number 2. Conditional

1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00004"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 30 characters or less 2. Value must be in Managed Care Service Area Name List (VVL) 3. If associated Managed Care Service Area (MCR.002.029) is in [2,3,4,5,6], then value is mandatory and must be provided 4. Value must not contain a pipe or asterisk symbol 5. Conditional 6. If associated Managed Care Service Area (MCR.002.029) equals "5" (zip code), then value must be a 5-digit zip code 7. If associated Managed Care Service Area (MCR.002.029) equals "2" (county code), then value must be a 3-digit number
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00005"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 2 characters 2. Value must be in Operating Authority List (VVL) 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00006"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 2 characters 2. Value must be in Managed Care Plan Pop List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00007"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 2 characters 2. Value must be in Accreditation Organization List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00010"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)

1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 2 characters 2. Value must be in Managed Care Plan Other ID Type List (VVL) 3. Mandatory
1. Value must be 30 characters 2. Value must not contain a pipe or asterisk symbol 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00001"
1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
1. Value must be 1 character 2. Value must be in Subcaptitation Indicator List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) 3. Mandatory
1. Value must be 9 characters or less 2. Mandatory

1. Value must equal "PROVIDER" 2. Mandatory
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same for all records
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created 3. Value must be before associated End of Time Period 4. Mandatory 5. Value of the CC component must be "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be equal to or earlier than associated Date File Created 4. Value must be equal to or after associated Start of Time Period 5. Mandatory
1. Value must be 1 character 2. For production files, value must be equal to "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
1. Value must be 11 digits or less 2. Value must be a positive integer 3. Value must be between 0:99999999999 (inclusive) 4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
1. Value must be 2 characters 2. Value must be in File Submission Method List (VVL) 3. Mandatory
1. Value must be 4 characters or less 2. Value must between 1 and 9999 3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) 4. Value must not contain a pipe symbol 5. Mandatory

1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00002"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 30 characters or less 2. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 100 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Conditional
1. Value must be 100 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Mandatory
1. Value must be 60 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Conditional

1. Value must be 100 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Mandatory
1. Value must be in Facility Group Individual Code List (VVL) 2. Value must be 2 characters 3. Mandatory 4. (Individual) If value equals "03", then Provider First Name (PRV.002.028) must be populated 5. (Individual) NPPES Entity Type Code associate with this NPI must equal "1" (Individual) 6. (Individual) If value equals "03", then Provider Last Name (PRV.002.030) must be populated 7. (Individual) If value equals "03", then Provider Sex (PRV.002.031) must be populated 8. (Individual) If value equals "03", then Provider Date of Birth (PRV.002.034) must be populated 9. (Organization) If value equals "01" or "02", then Provider Date of Death (PRV.002.035) must not be populated 10. (Organization) If value does not equal "03", then Provider Middle Initial (PRV.002.029) must not be populated 11. (Organization) NPPES Entity Type Code associate with this NPI must equal "2" (Organization)
1. Value must be 1 character 2. Value must be in Teaching Indicator List (VVL) 3. Value must be "0" when Facility Group Individual Code (PRV.002.026) equals '02' or '03' 4. Conditional
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 1 character 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 1 character 2. Value must be in Sex List (VVL) 3. Conditional
1. Value must be 2 characters 2. Value must be in Ownership Code List (VVL) 3. Conditional 4. Value is mandatory when associated Facility Group Individual Code (PRV.002.026) is in [01,02] (organization)

1. Value must be 2 characters 2. Value must be in Provider Profit Status List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period (PRV.001.010) 3. Conditional 4. The difference between current value and Start of Time Period (PRV.001.009) must be between 18 and 85 years
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Conditional 3. If populated, value must be on or after individual's Date of Birth 4. Value must be less than or equal to associated End of Time Period (PRV.001.010) 5. There can only be one value on all records when the value is populated 6. When populated, the difference between value and Date of Birth (PRV.002.034) must be 18 years or greater
1. Value must be 1 character 2. Value must be in Accepting New Patients Indicator List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in Atypical Provider Indicator code list (VVL) 3. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00003"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 30 characters or less 2. Mandatory

1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,19,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 1 character 2. Value must be in Provider Address Type List (VVL) 3. Mandatory
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. Mandatory
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 2 value(s) 3. If Address Line 2 is not populated, then value should not be populated 4. Value must not contain a pipe or asterisk symbols 5. Conditional
1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory
1. Value must be 10-digit number 2. Situational
1. Must contain the "@" symbol 2. May contain uppercase and lowercase Latin letters A to Z and a to z 3. May contain digits 0-9 4. Must contain a dot "." that is not the first or last character and provided that it does not appear consecutively 5. Value must be 60 characters or less 6. Situational
1. Value must be 10-digit number 2. Situational
1. Value must be 1 character 2. Value must be in Address Border State Indicator List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in US County Code List (VVL) 3. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00004"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory

1. Value must be 30 characters or less 2. Mandatory
1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 1 character 2. Value must be in License Type List (VVL) 3. Mandatory
1. Value must be 60 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Mandatory 4. If associated License Type equals "2", then value must equal "DEA"

1. Value must be 20 characters or less 2. Value must not contain a pipe and asterisk symbol 3. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00005"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 1 character 2. Value must be in Provider Identifier Type List (VVL) 3. Mandatory 4. When value equals "2", the associated Provider Identifier (PRV.005.081) must be a valid NPI

1. Value must be 18 characters or less 2. Value must not contain a pipe or asterisk symbol 3. (State-specific Medicaid Provider) if associated Provider Identifier Type (PRV.005.077) value equals "1", then value must equal (PRV.005.073) Submitting State 4. (NPI) if associated Provider Identifier Type (PRV.005.077) value equals "2", then value must equal "NPI" 5. (Medicare) if associated Provider Identifier Type (PRV.005.077) value equals "3", then value must equal "CMS" 6. (NCPDP) if associated Provider Identifier Type (PRV.005.077) value equals "4", then value must equal "NCPDP" 7. (Federal Tax ID) if associated Provider Identifier Type (PRV.005.077) value equals "5", then value must equal "IRS" 8. (SSN) if associated Provider Identifier Type (PRV.005.077) value equals "7", then value must be equal to "SSA" 9. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 30 characters or less 2. Mandatory 3. Value must not contain a pipe or asterisk symbol 4. Value must have an associated Provider Identifier Type (PRV.005.077) 5. One record must have a Provider Identifier Type (PRV.005.077) equal to "1"
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00006"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in Provider Classification Type List (VVL) 3. Mandatory
1. Value must be 20 characters or less 2. If associated Provider Classification Type equals "1", value must be in Provider Taxonomy List (VVL) 3. If associated Provider Classification Type equals "2", value must be in Provider Specialty List (VVL) 4. If associated Provider Classification Type equals "3", value must be in Provider Type Code List (VVL) 5. If associated Provider Classification Type equals "4", value must be in Provider Authorized Category of Service Code List (VVL) 6. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00007"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 30 characters or less 2. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 2 characters 2. Value must be in Provider Medicaid Enrollment Status Code List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in State Plan Enrollment List (VVL) 3. Mandatory
1. Value must be 1 character 2. Value must be in Provider Enrollment Method List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must not be earlier than associated Provider Medicaid Effective Date (PRV.007.098) value 3. Mandatory

1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00008"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 30 characters or less 2. Value must not contain a pipe symbol 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00009"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in Affiliated Program Type List (VVL) 3. Mandatory
1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00010"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 30 characters or less 2. Mandatory
1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 1 character 2. Value must be in Bed Type Code List (VVL) 3. Mandatory

1. Value must be 5 digits or less 2. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00001"
1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
1. Value must be 1 character 2. Value must be in Subcaptitation Indicator List (VVL) 3. Mandatory
1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) 3. Mandatory
1. Value must be 9 characters or less 2. Mandatory
1. Value must equal "TPL-FILE" 2. Mandatory
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same for all records
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created 3. Value must be before associated End of Time Period 4. Mandatory 5. Value of the CC component must be "20"
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be equal to or earlier than associated Date File Created 4. Value must be equal to or after associated Start of Time Period 5. Mandatory
1. Value must be 1 character 2. For production files, value must be equal to "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) 3. Mandatory
1. Value must be 11 digits or less 2. Value must be a positive integer 3. Value must be between 0:99999999999 (inclusive) 4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
1. Value must be 2 characters 2. Value must be in File Submission Method List (VVL) 3. Mandatory
1. Value must be 4 characters or less 2. Value must between 1 and 9999 3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) 4. Value must not contain a pipe symbol 5. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00002"

1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (TPL.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 1 character 2. Value must be in [0, 1] or not populated 3. Value must be in TPL Health Insurance Coverage Indicator List (VVL) 4. Mandatory 5. When value equals "1", there must be one corresponding TPL Medicaid Eligible Person Health Insurance Coverage Information (TPL.003) segment with the same MSIS ID
1. Value must be 1 character 2. Value must be in TPL Other Coverage Indicator List (VVL) 3. Mandatory
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 1 character 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00003"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (TPL.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional

1. Value must be 16 characters or less 2. Value must not contain a pipe symbol 3. Conditional
1. Value must be 20 characters or less 2. Value must not contain a pipe symbol 3. Conditional
1. Value must be 2 characters or less 2. Value must be in Insurance Plan Type List (VVL) 3. Conditional 4. Value must have an associated Insurance Plan ID
1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
1. Value must be 30 characters or less 2. Value must not contain a pipe symbol 3. Mandatory
1. Value must be 30 characters or less 2. Value must not contain a pipe symbol 3. Mandatory
1. Value must be 9-digit number 2. For any individual, the value must be the same over all segment effective and end dates 3. Conditional
1. Value must be 2 characters 2. Value must be in Policy Owner Code List (VVL) 3. Conditional
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]

1. Value must be 2 characters 2. Value must be in Coverage Type List (VVL) 3. Mandatory
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00004"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (TPL.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Mandatory 2. Value must be 12 characters or less 3. Value must not contain a pipe or asterisk symbols
1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 2 characters or less 2. Value must be in Insurance Plan Type List (VVL) 3. Mandatory 4. Value must have an associated Insurance Plan ID
1. Value must be 2 characters 2. Value must be in Coverage Type List (VVL) 3. Mandatory

1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00005"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (TPL.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 20 characters or less 2. Mandatory

1. Value must be 1 character 2. Value must be in Type of Other Third-Party Liability List (VVL) 3. Mandatory
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99] 5. Value must occur on or before individual's Date of Death (ELG.002.025) when populated
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00006"
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (TPL.001.007)
1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
1. Value must be 2 characters 2. Value must be in TPL Entity Address Type List (VVL) 3. Mandatory

1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. Situational 5. When populated, the associated Address Type is required
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 2 value(s) 3. If Address Line 2 is not populated, then value should not be populated 4. Value must not contain a pipe or asterisk symbols 5. Conditional
1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Situational
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Situational
1. Value must be 10-digit number 2. Situational
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [18,19,20,99]
1. Value must be 10 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational