COL	FIELD	LENGTH	NOTES
1	PATIENT ID **(patient_id)**	11	Use First 10 Characters only for SEER cases.
	SEER Cases (Patient ID)		
1	Registry	2	02 = Connecticut 20 = Detroit 21 = Hawaii 22 = Iowa 23 = New Mexico 25 = Seattle 26 = Utah 42 = Kentucky 43 = Louisiana 44 = New Jersey 87 = Georgia 88 = California
3	Case Number	8	Encrypted SEER Case Number
11	Filler	1	Blank Space
	Non Cancer Patients (Patient ID)		
1	HIC ID **(hicbic)**	11	Encrypted ID for Non Cancer Patients
12	NCH CLAIM TYPE CODE (7) **(clm_type)**	2	The code used to identify the type of Claim record being processed in NCH. 10 = HHA claim 20 = Non swing bed SNF claim 30 = Swing bed SNF claim 40 = Outpatient claim 41 = Outpatient 'Full-Encounter' claim (available in NMUD) 42 = Outpatient 'Abbreviated – Encounter' (available in NMUD) 50 = Hospice claim 60 = Inpatient claim 61 = Inpatient 'Full-Encounter' claim 62 = Medicare Advantage IME/GME claims 63 = Medicare Advantage (no-pay) claims 64 = Medicare Advantage (paid as FFS) claims 71 = RIC O local carrier non-DMEPOS Claim 72 = RIC O local carrier DMEPOS claim 73 = Physician 'Full-Encounter' claim (Available in NMUD) 81 = RIC M DMERC non-DMEPOS claim 82 = RIC M DMERC DMEPOS claim

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

COL	FIELD	LENGTH	NOTES
14	NCH CATEGORY EQUATABLE BENEFICIARY IDENTIFICATION CODE (11) **(eq_bic)**	2	The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner.
16	BENEFICIARY IDENTIFICATION CODE (12) **(bic)**	2	Relationship between individual and a primary Social Security Administration Beneficiary. (Refer to appendix table BIC)
18	BENEFICIARY RESIDENCE SSA STANDARD STATE CODE (14) **(state_cd)**	2	State of Beneficiary's residence, SSA Standard Code. (Refer to appendix table STATE_CD)
20	CLAIM FROM DATE (15) **(from_dtm, from_dtd, from_dty)**	8	For Institutional or CWFB Claim, first day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
28	CLAIM THROUGH DATE (16) **(thru_dtm, thru_dtd, thru_dty)**	8	Last day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
62	CLAIM TOTAL LINE COUNT (26) **(linecnt)**	2	The count of the number of line items on the carrier claim.
65	CARRIER CLAIM ENTRY CODE (30) **(entry_cd)**	1	Generated by Carrier. 1 = *Original debit 3 = Full credit 5 = Replacement debit 9 = Accrete bill history only (Internal; effective 2/22/91) *if claim disposition code = 3, entry code = 1 means original debit was voided.
66	BENEFICIARY RESIDENCE SSA STANDARD COUNTY CODE (35) **(cnty_cd)**	3	County of Beneficiary's residence, SSA Standard Code.
69	CARRIER NUMBER (39) **(carr_num)**	5	Assigned by CMS to an Intermediary or Carrier authorized to process claims from Providers or Physician/Suppliers. (Refer to appendix table CARR_NUM)
74	BENEFICIARY MAILING CONTACT ZIP CODE (42) **(bene_zip)**	9	Beneficiary's mailing address zip code. ***Encrypted data. Special permission required for unencrypted data.**

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COL	FIELD	LENGTH	NOTES
83	CWF BENEFICIARY MEDICARE STATUS CODE (46) **(ms_cd)**	2	Medicare entitlement reason 10 = Aged without ESRD 11 = Aged with ESRD 20 = Disabled without ESRD 21 = Disabled with ESRD 31 = ESRD only
85	CLAIM PRINCIPAL DIAGNOSIS VERSION CODE (52) **(pdvrsncd)**	1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10
86	PRINCIPAL DIAGNOSIS CODE (53) **(pdgns_cd)**	7	Beneficiary's principal diagnosis code.
93	CARRIER CLAIM PAYMENT DENIAL CODE (55) **(pmtdnlcd)**	2	Indicates to whom payment was made, or if a claim was denied. (Refer to appendix table PMTDNLCD)
95	CLAIM PAYMENT AMOUNT (57) **(pmt_amt)**	15.2	Amount of payment made from the Medicare trust fund for the services covered by the claim record.
110	CARRIER CLAIM PRIMARY PAYER PAID AMOUNT (58) **(prpayamt)**	15.2	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.
125	DMERC CLAIM ORDERING PHYSICIAN UPIN NUMBER (60) **(ord_upin)**	6	Unique Physician Identification Number (UPIN) number of physician ordering the Part B services/DMEPOS item. **Encrypted data.**
131	DMERC CLAIM ORDERING PHYSICIAN NPI NUMBER (61) **(ord_npi)**	10	The NPI assigned to the physician ordering the Part B services/DMEPOS item. The NPI may not be available prior to 7/1/2007. **Encrypted data.**
141	CARRIER CLAIM PROVIDER ASSIGNMENT INDICATOR SWITCH (62) **(asgmntcd)**	1	A switch indicating whether or not the provider accepts assignment for the noninstitutional claim A = Assigned claim N = Non-assigned claim
142	NCH CLAIM PROVIDER PAYMENT AMOUNT (63) **(prov_pmt)**	15.2	The total payments made to the provider for this claim (sum of line item provider payment amounts).
157	NCH CLAIM BENEFICIARY PAYMENT AMOUNT (64) **(bene_pmt)**	15.2	The total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.)

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COL	FIELD	LENGTH	NOTES
172	CARRIER CLAIM BENEFICIARY PAID AMOUNT (65) **(benepaid)**	15.2	The amount paid by the beneficiary for the non-institutional Part B services.
187	NCH CARRIER CLAIM SUBMITTED CHARGE AMOUNT (66) **(sbmtchrg)**	15.2	The total submitted charges on the claim (the sum of line item submitted charges).
202	NCH CLAIM ALLOWED CHARGE AMOUNT (67) **(alowchrg)**	15.2	The total allowed charges on the claim (the sum of line item allowed charges).
217	CARRIER CLAIM CASH DEDUCTIBLE APPLIED AMOUNT (68) **(dedapply)**	15.2	The amount of the cash deductible as submitted on the claim.
232	CARRIER CLAIM HCPCS YEAR CODE (69) **(hcpcs_yr)**	1	The terminal digit of HCPCS version used to code the claim.
233	CLAIM DIAGNOSIS CODE COUNT (93) **(ddgncnt)**	2	The count of the number of diagnosis codes (both principal and secondary) reported on a DMERC claim. The purpose of this count is to indicate how many claim diagnosis code trailers are present.
235	CLAIM DIAGNOSIS VERSION CODE (121) **(dvrsncd1-dvrsncd12)**	12*1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10
247	CLAIM DIAGNOSIS CODE (122) **(dgns_cd1-dgns_cd12)**	12*7	Up to twelve 7 digit ICD diagnosis codes. For persons with less than twelve codes the columns are blank filled.
331	DMERC LINE SUPPLIER PROVIDER NUMBER (125) **(suplrnum)**	10	Effective with Version G, billing number assigned to the supplier of the Part B service/DMEPOS by the National Supplier Clearinghouse, as reported on the line item for the DMERC claim.
341	DMERC LINE ITEM SUPPLIER NPI NUMBER (126) **(sup_npi)**	10	The NPI assigned to the supplier of the Part B service/DMEPOS line item. The NPI may not be available prior to 7/1/2007. **Encrypted data.**
351	DMERC LINE PRICING STATE CODE (127) **(prcng_st)**	2	The state code for the pricing the service. (Refer to appendix table STATE_CD).

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COL	FIELD	LENGTH	NOTES
353	LINE PRICING ZIP CODE (128) **(prcngzip)**	9	The zip code used to identify where the supply/item was rendered. The pricing state code and the pricing zip code will be used in pricing DMEPOS claims. ***Encrypted data. Special permission required for unencrypted data.**
362	NCH/DMERC LINE PROVIDER STATE CODE (130) **(prvstate)**	2	Effective with Version G, the SSA standard state code (converted from the state postal abbreviation) representing the supplier's location, as reported on the DMERC line item. (Refer to appendix table STATE_CD)
364	DMERC LINE SUPPLIER TYPE CODE (131) **(sup_type)**	1	Code identifying the type of supplier furnishing the line item service on the DMERC claim. (Refer to appendix table SUP_TYPE)
365	LINE PROVIDER TAX NUMBER (132) **(tax_num)**	10	Social security number or employee identification number of physician/supplier used to identify to whom payment is made for the line item service on the non-institutional claim. ***Encrypted data.**
375	LINE HCFA PROVIDER SPECIALTY CODE (133) **(hcfaspcl)**	2	HCFA Specialty code used for pricing the service for this line item on the CWFB claim. (Refer to appendix table HCFASPCL)
377	LINE PROVIDER PARTICIPATING INDICATOR CODE (134) **(prtcptg)**	1	Code indicating whether or not a provider is participating or accepting assignment for this line item on the Part B claim. (Refer to appendix table PRTCPTG).
378	LINE SERVICE COUNT (135) **(srvc_cnt)**	12	Count of the total number of services processed.
390	LINE HCFA TYPE SERVICE CODE (136) **(typsrvcb)**	1	Carrier's type of service code (usually different from HCFA's) used for pricing this service. (Refer to appendix table TYPSRVCB)
391	LINE PLACE OF SERVICE CODE (137) **(plcsrvc)**	2	Place of service for this procedure code. (Refer to appendix table PLCSRVC)
393	LINE FIRST EXPENSE DATE (138) **(expnsdt1m, expnsdt1d, expnsdt1y)**	8	Beginning date of this service. MMDDYYYY
401	LINE LAST EXPENSE DATE (139) **(expnsdt2m, expnsdt2d, expnsdt2y)**	8	Ending date for this service. MMDDYYYY

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COL	FIELD	LENGTH	NOTES
409	LINE HCPCS CODE (140) **(hcpcs_cd)**	5	Health Care Financing Administration Common Procedure Coding System (HCPCS) code. Procedures, supplies, products or services provided to Medicare Beneficiaries. (Refer to appendix table HCPCS_CD)
414	LINE HCPCS INITIAL MODIFIER CODE (141) **(mdfr_cd1)**	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information File)
416	LINE HCPCS SECOND MODIFIER CODE (142) **(mdfr_cd2)**	2	Second modifier to enable a more specific procedure ID (Carrier Information File)
418	LINE HCPCS THIRD MODIFIER CODE (143) **(mdfr_cd3)**	2	Third modifier to the HCPCS procedure code used to process the DMERC line item.
420	LINE HCPCS FOURTH MODIFIER CODE (144) **(mdfr_cd4)**	2	Fourth modifier to the HCPCS procedure code used to process the DMERC line item.
422	LINE NATIONAL DRUG CODE (148) **(ndc_cd)**	11	The National Drug Code identifies the oral anti-cancer drugs.
433	LINE NCH PAYMENT AMOUNT (149) **(linepmt)**	15.2	Amount of payment made to provider and/or beneficiary for the services covered
448	LINE BENEFICIARY PAYMENT AMOUNT (150) **(lbenpmt)**	15.2	The payment (reimbursement) made to the beneficiary related to the line item service on the non-institutional claim.
463	LINE PROVIDER PAYMENT AMOUNT (151) **(lprvpmt)**	15.2	The payment made to the provider for the line item service on the non-institutional claim.
478	LINE BENEFICIARY PART B DEDUCTIBLE AMOUNT (152) **(ldedamt)**	15.2	The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B deductible on the CWFB claim.
493	LINE BENEFICIARY PRIMARY PAYER CODE (153) **(lprpaycd)**	1	Specifies a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills. (Refer to appendix table PRPAY_CD)
494	LINE BENEFICIARY PRIMARY PAYER PAID AMOUNT (154) **(lprpdamt)**	15.2	Amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a CWFB claim.

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COL	FIELD	LENGTH	NOTES
509	LINE COINSURANCE AMOUNT (155) **(coinamt)**	15.2	The payment made to the provider for the line item service on the non-institutional claim.
524	LINE INTEREST AMOUNT (156) **(lint_amt)**	15.2	Amount of interest to be paid on this line item.
539	LINE PRIMARY PAYER ALLOWED CHARGE AMOUNT (157) **(prpyalow)**	15.2	The primary payer allowed charge amount for the line item service on the non-institutional claim.
554	LINE SUBMITTED CHARGE AMOUNT (159) **(lsbmtchg)**	15.2	The amount of submitted charges reported on the line item on the CWFB claim.
569	LINE ALLOWED CHARGE AMOUNT (160) **(lalowchg)**	15.2	The amount of allowed charges reported on the line item on the CWFB claim.
584	LINE DME PURCHASE PRICE AMOUNT (162) **(dme_purc)**	15.2	The amount representing the lower of fee schedule for purchase of new or used DME, or actual charge.
599	LINE PROCESSING INDICATOR CODE (163) **(prcngind)**	2	The code indicating the reason a line item on the CWFB claim was allowed or denied. (Refer to appendix table PRCNGIND).
601	LINE PAYMENT 80/100% CODE (164) **(pmtindsw)**	1	The code indicating that the amount shown in the payment field on the CWFB claim represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only. 0 = 80% 1 = 100% 3 = 100% limitation of liability only 4 = 75% Reimbursement
602	LINE SERVICE DEDUCTIBLE INDICATOR SWITCH (165) **(ded_sw)**	1	Switch indicating whether or not the service reflected on the line item on the CWFB claim is subject to deductible. 0 = Service Subject to Deductible 1 = Service Not Subject to Deductible
603	LINE PAYMENT INDICATOR CODE (166) **(pmtindcd)**	1	Code that indicates the payment screen used to determine the allowed charge for the line item on the CWFB claim. (Refer to appendix table PMTINDCD).
604	CARRIER MILES/TIME/UNITS/SERVICES COUNT (167) **(mtus_cnt)**	12.3	The count of the total units associated with services needing unit reporting such as transportation, miles anesthesia time units, number of services, volume of oxygen or blood units. This is a line item on the CWFB claim and is used for both allowed and denied services.

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COL	FIELD	LENGTH	NOTES
616	CARRIER MILES/TIME/UNITS/SERVICES INDICATOR CODE (168) **(mtus_ind)**	1	Code indicating the units associated with services needing unit reporting on the line item for the CWFB claim. 0 = Values reported as zero 3 = Number of services 4 = Oxygen volume units 6 = Drug Dosage – since early 1994 this value has incorrectly been placed on DMERC claims. The DMERCs were overriding the MTUS indicator with a '6' if the claim was submitted with an NDC code. NOTE: It was recently discovered that this problem has been corrected – no date on when the correction became effective.
617	LINE DIAGNOSIS VERSION CODE (170) **(ldvrsncd)**	1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10
618	LINE DIAGNOSIS CODE (171) **(linedgns)**	7	ICD code indicating diagnosis supporting this procedure/service.
625	LINE ADDITIONAL CLAIM DOCUMENTATION INDICATOR CODE (172) **(dcmtn_cd)**	1	Code indicating additional claim documentation was submitted. (Refer to appendix table DCMTN_CD).
626	LINE WAIVER OF PROVIDER LIABILITY SWITCH (175) **(waiversw)**	1	The switch indicating the beneficiary was notified that the item, reported as a DMERC line item, may not be considered medically necessary and has agreed in writing to pay for the item. Y = Yes N = No
627	YEAR OF CLAIMS FILE **(year)**	4	Year of the file.
631	RECORD COUNT FOR CLAIM **(rec_count)**	3	Record count for claim
634	CLAIM ID **(claim_id)**	10	ID to index unique claims
644	Filler	1	

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