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 **(hicbic)**	11	Encrypted ID for Non Cancer Patients
12	NCH NEAR LINE RECORD IDENTIFICATION CODE (5) **(ric_cd)**	1	Claim Near-Line Record Identification O = Part B (CWFB) Physician/Supplier Claim Record V = Part A Institutional claim record (Inpatient (IP), Skilled Nursing Facility (SNF), Christian Science (CS), Home Health Agency (HHA) or Hospice) W = Part B Institutional claim record (Outpatient (OP), HHA) M = Part B (CWFB) DMEPOS claim record (Effective 10/93) U = Both Part A and B institutional HHA claim records - due to HHPPS and HHA A/B split. (eff. 10/00)

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COL	FIELD	LENGTH	NOTES
13	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' claim (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
15	BENEFICIARY IDENTIFICATION CODE (12) **(bic)**	2	Relationship between individual and a primary Social Security Administration Beneficiary. (Refer to appendix table BIC)
17	SSA STANDARD STATE CODE (14) **(state_cd)**	2	State of Beneficiary's residence, SSA Standard Code. (Refer to appendix table STATE_CD)
19	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
27	CLAIM THROUGH DATE (16) **(thru_dtm, thru_dtd, thru_dty)**	8	Last day of Provider's or Physician/Supplier's Billing statement. MMDDYYYY

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COL	FIELD	LENGTH	NOTES
35	CLAIM QUERY CODE (22) **(query_cd)**	1	Payment type of claim being processed. 0 = Credit adjustment 1 = Interim bill 2 = Home Health Agency benefits exhausted (obsolete 7/98) 3 = Final bill 4 = Discharge notice (obsolete 7/98) 5 = Debit adjustment
36	PROVIDER NUMBER (23) **(provider)**	6	ID of Medicare Provider certified to provide services to the Beneficiary. ***Encrypted Data. Special Permission required to receive unencrypted data.** For more information: **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R82SOMA.pdf**
60	CLAIM TOTAL SEGMENT COUNT (26) **(sgmt_cnt)**	2	Total number of segments for each claim. (corresponds to total number of original var-length records for each claim. Max = 10)
62	CLAIM SEGMENT NUMBER (27) **(sgmt_num)**	2	Number of each segment. (corresponds to the original var-length record for this claim. Values: 1 to 10)
64	CLAIM TOTAL LINE COUNT (28) **(linecnt)**	3	The total number of Revenue Center lines associated with the claim.
67	CLAIM SEGMENT LINE COUNT (29) **(sgmtline)**	2	The count used to identify the number of lines on a record/segment.
69	CLAIM FACILITY TYPE CODE (34) **(fac_type)**	1	Facility that provided care. (Refer to appendix table FAC_TYPE)
70	CLAIM SERVICE CLASSIFICATION TYPE CODE (35) **(typesrvc)**	1	Classification of type of service provided to the Beneficiary. (Refer to appendix table TYPESRVC).
71	CLAIM FREQUENCY CODE (36) **(freq_cd)**	1	Sequence of claim in the Beneficiary's current episode of care associated with a given facility. (Refer to appendix table FREQ_CD).

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COL	FIELD	LENGTH	NOTES
72	BENEFICIARY RESIDENCE SSA STANDARD COUNTY CODE (42) **(cnty_cd)**	3	County of Beneficiary's residence, SSA Standard Code.
75	FI NUMBER (46) **(fi_num)**	5	Assigned by CMS to an Intermediary or Carrier authorized to process claims from Providers or Physician/Suppliers. (Refer to appendix table FI_NUM for Outpatient, HHA, Hospice)
80	BENEFICIARY MAILING CONTACT ZIP CODE (49) **(bene_zip)**	9	Beneficiary's mailing address zip code. ***Encrypted Data. Special Permission required to receive unencrypted data.**
89	CWF BENEFICIARY MEDICARE STATUS (53) **(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
91	CLAIM MEDICARE NON PAYMENT REASON CODE (62) **(nopay_cd)**	2	The reason that no Medicare payment is made for services on an institutional claim. (Refer to appendix table NOPAY_CD).
93	CLAIM PAYMENT AMOUNT (64) **(pmt_amt)**	15.2	Made to Provider and/or Beneficiary from trust fund (after deductible and coinsurance amounts) for services covered by Institutional claim (does not include pass-through per diem or organ acquisition), or for Physician/Supplier claim. Does not include automatic adjustments. NOTE: If more than one record from the same claim (sorted by Patient ID, Claim ID and Rec_count) is selected, be sure to keep the claim payment amount from the first record only.
108	NCH PRIMARY PAYER CLAIM PAID AMOUNT (65) **(prpayamt)**	15.2	Made on behalf of Beneficiary by a primary payer other than Medicare. Provider is applying to covered Medicare charges on Institutional or CWFB claim.

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COL	FIELD	LENGTH	NOTES
123	NCH PRIMARY PAYER CODE (66) **(prpay_cd)**	1	Federal non-Medicaid program or other source with primary responsibility for payment of Beneficiary's medical bills. (Refer to appendix table PRPAY_CD)
124	FI CLAIM ACTION CODE (68) **(actioncd)**	1	Action requested by Intermediary to be taken on an Institutional claim. (Refer to appendix table ACTIONCD).
125	NCH PROVIDER STATE CODE (70) **(prstate)**	2	SSA state code where provider facility is located. (Refer to appendix table STATE_CD).
127	ORGANIZATION NPI NUMBER (71) **(orgnpinm)**	10	The NPI assigned to the institutional provider. The NPI may not be available prior to 7/1/2007. **Encrypted Data. * Special permission required to receive unencrypted data.**
137	CLAIM ATTENDING PHYSICIAN UPIN NUMBER (73) **(at_upin)**	6	Institutional claim's state license number or other identifier (like UPIN, required since 1/92) of Physician expected to certify medical necessity of services rendered and/or has primary responsibility for Beneficiary's medical care and treatment. ***Encrypted Data.**
143	CLAIM ATTENDING PHYSICIAN NPI NUMBER (74) **(at_npi)**	10	The NPI assigned to the attending physician. The NPI may not be available prior to 7/1/2007. ***Encrypted Data.**
153	CLAIM OPERATING PHYSICIAN UPIN NUMBER (79) **(op_upin)**	6	The unique physician ID number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure. ***Encrypted Data.**
159	CLAIM OPERATING PHYSICIAN NPI NUMBER (80) **(op_npi)**	10	The NPI assigned to the operating physician. The NPI may not be available prior to 7/1/2007. ***Encrypted Data.**
169	CLAIM OTHER PHYSICIAN UPIN NUMBER (85) **(ot_upin)**	6	On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim. ***Encrypted Data.**
175	CLAIM OTHER PHYSICIAN NPI NUMBER (86) **(ot_npi)**	10	The NPI assigned to the other physician. The NPI may not be available prior to 7/1/2007. ***Encrypted Data.**

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COL	FIELD	LENGTH	NOTES
185	CLAIM TREATMENT AUTHORIZATION NUMBER (93) **(authrztn)**	18	The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case.
203	PATIENT DISCHARGE STATUS CODE (98) **(stus_cd)**	2	Status of Beneficiary as of Service Through Date on a claim. (Refer to appendix table STUS_CD).
205	CLAIM PPS INDICATOR CODE (102) **(pps_ind)**	1	The code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee. (Refer to appendix table PPS_IND)
206	CLAIM TOTAL CHARGE AMOUNT (103) **(tot_chrg)**	15.2	Total charges for all services included on the institutional claim.
221	CLAIM PRICER RETURN CODE (104) **(prcrrtrn)**	2	This code identifies the payment return code or the error return code for every claim type calculated by a PRICER (Inpatient, Outpatient, SNF, Inpatient Rehab Facility (IRF), Home Health and Hospice). (Refer to appendix table PRCRRTRN)
223	CLAIM SERVICE FACILITY ZIP CODE (108) **(srvcfac)**	9	The zip code used to identify the location of the facility where the service was performed. ***Encrypted Data. Special Permission required to receive unencrypted data.** Note: This variable is only available in 2010+.
232	HHA CLAIM DIAGNOSIS CODE COUNT (144) **(hhdgncnt)**	2	The count of the number of diagnosis codes (both principal and secondary) reported on a Home Health Agency (HHA) claim. The purpose of this count is to indicate how many claim diagnosis trailers are present.
234	HHA REVENUE CENTER CODE COUNT (151) **(hhrevcnt)**	2	The count of the number of revenue codes reported on an HHA claim. The purpose of the count is to indicate how many revenue center trailers are present.
236	CLAIM HHA LOW UTILIZATION PAYMENT ADJUSTMENT (LUPA) INDICATOR CODE (154) **(lupaind)**	1	The code used to identify those Home Health PPS claims that have 4 visits or less in a 60-day episode. (Refer to appendix table LUPAIND)

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COL	FIELD	LENGTH	NOTES
237	CLAIM HHA REFERRAL CODE (155) **(hha_rfrl)**	1	The code used to identify the means by which the beneficiary was referred for Home Health services. (Refer to appendix table HHA_RFRL)
238	CLAIM HHA TOTAL VISIT COUNT (156) **(visitcnt)**	4	The count of the number of HHA visits as derived by CWF.
241	NCH BENEFICIARY DISCHARGE DATE (159) **(dschrgdtm, dschrgdtd, dschrgdty)**	8	The date the beneficiary was discharged from the facility or died (used for internal CWFMQA editing purposes.) MMDDYYYY
249	CLAIM HHA CARE START DATE (160) **(hhstrdtm, hhstrdtd, hhstrdty)**	8	The date care started for the HHA services reported on the institutional claim with a from date greater than 3/31/98. The Balanced Budget Act (BBA) required that this field be present on all HHA claims. MMDDYYYY
257	Claim Service Location NPI Number (171) **(srvcnpi)**	10	The NPI assigned to the claims service center. The NPI may not be available prior to 1/2013. ***Encrypted Data**
267	CLAIM DIAGNOSIS VERSION CODE (194) **(dvrsncd1-dvrsncd25)**	25*1	ICD diagnosis version code: 9 = ICD-9 0 = ICD-10
292	CLAIM DIAGNOSIS CODE (195) **(dgns_cd1-dgns_cd25)**	25*7	ICD-CM codes of any coexisting conditions shown in medical record as affecting services provided. Up to 25 codes may be listed, each with 7 digits.
467	CLAIM RELATED CONDITION CODE (202) **(rlt_cond1-2)**	2*2	The code that indicates a condition relating to an institutional claim that may affect payer processing. (Refer to appendix table RLT_COND)
471	NCH OCCURRENCE TRAILER INDICATOR CODE (204) **(ocrncind1-ocrncind2)**	2*1	The code indicating the presence of an occurrence code trailer. O = Occurrence code trailer present
473	CLAIM RELATED OCCURRENCE CODE (205) **(ocrnc_cd1- ocrnc_cd2)**	2*2	The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date. (Refer to appendix table OCRNC_CD)

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COL	FIELD	LENGTH	NOTES
477	CLAIM RELATED OCCURRENCE DATE 1 (206) **(ocrncdtm1, ocrncdtd1, ocrncdty1)**	8	The date associated with the first significant event related to an institutional claim that may affect payer processing. MMDDYYYY
485	CLAIM RELATED OCCURRENCE DATE 2 (206) **(ocrncdtm2, ocrncdtd2, ocrncdty2)**	8	The date associated with the second significant event related to an institutional claim that may affect payer processing. MMDDYYYY
493	REVENUE CENTER CODE (218) **(rev_cntr)**	4	Cost center (division or unit within a hospital) for which a separate charge is billed (type of accommodation or ancillary). Assigned by provider. (Refer to appendix table REV_CNTR)
497	REVENUE CENTER DATE (219) **(rev_dtm, rev_dtd, rev_dty)**	8	The date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with the "from date" greater than 3/31/98. With the implementation of outpatient PPS, hospitals with be required to enter line item dates of service for all outpatient services which require a HCPCS. MMDDYYYY
505	REVENUE CENTER 1ST ANSI CODE (220) **(revansi1)**	5	The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment). (Refer to appendix table REVANSI1)
510	REVENUE CENTER APC/HIPPS (224) **(apchipps)**	5	This field was created to house two pieces of data. The Ambulatory Payment Classification (APC) code and the HIPPS code. (Refer to appendix table HCPCS)
515	REVENUE CENTER HEALTHCARE COMMON PROCEDURE CODING SYSTEM (225) **(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)
520	REVENUE CENTER HCPCS INITIAL MODIFIER CODE (226) **(mdfr_cd1)**	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information file)
522	REVENUE CENTER HCPCS SECOND MODIFIER CODE (227) **(mdfr_cd2)**	2	Second modifier to the procedure code to enable a more specific procedure ID. (Carrier Information file)

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COL	FIELD	LENGTH	NOTES
524	REVENUE CENTER UNIT COUNT (239) **(rev_unit)**	8	A quantitative measure (unit) of services provided to a beneficiary associated with accommodation and ancillary revenue centers described on an institutional claim.
532	REVENUE CENTER RATE AMOUNT (240) **(rev_rate)**	15.2	Charges relating to unit cost associated with the revenue center code.
547	REVENUE CENTER 1ST MEDICARE SECONDARY PAYER PAID AMOUNT (245) **(rev_msp1)**	15.2	The amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary).
562	REVENUE CENTER 2ND MEDICARE SECONDARY PAYER PAID AMOUNT (246) **(rev_msp2)**	15.2	The amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).
577	REVENUE CENTER PROVIDER PAYMENT AMOUNT (247) **(rprvdpmt)**	15.2	The amount paid to the provider for the services reported on the line item.
592	REVENUE CENTER PAYMENT AMOUNT (250) **(revpmt)**	15.2	Medicare payment amount for the specific revenue center.
607	REVENUE CENTER TOTAL CHARGE AMOUNT (251) **(rev_chrg)**	15.2	Total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.
622	REVENUE CENTER NON-COVERED CHARGE AMOUNT (252) **(rev_ncvr)**	15.2	The charge amount related to a revenue center code for services that are not covered by Medicare.
637	REVENUE CENTER DEDUCTIBLE COINSURANCE CODE (253) **(revdedcd)**	1	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance. (Refer to appendix table REVDEDCD).
638	REVENUE CENTER STATUS INDICATOR CODE (255) **(rstusind)**	2	The code used to identify the status of the line item service. This field along with the payment method indicator field is used to identify how the service was priced for payment. (Refer to appendix table RSTUSIND)

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COL	FIELD	LENGTH	NOTES
640	REVENUE CENTER DUPLICATE CLAIM CHECK INDICATOR CODE (256) **(dup_chk)**	1	The code used to identify an item or service that appeared to be a duplicate but has been reviewed by an FI or MAC and appropriately approved for payment. 1 = Suspect duplicate review performed
641	YEAR OF CLAIMS FILE **(year)**	4	Year of the file.
645	RECORD COUNT FOR CLAIM **(rec_count)**	3	Counter for each claim.
648	CLAIM ID **(claim_id)**	10	ID to index unique claims
658	Filler	1	

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