



**ACS EDI Gateway Services
Electronic Claims Acquisition Services**

**District of Columbia
Department of Health
Medical Assistance Administration
UB92 Format
Version 5.0**

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Document Revision List

We make revisions to this document on an as-needed basis. To help you easily identify information that has changed, we provide a graphical element with the date of revision inside it. Depending on the chapter, the graphic is located in one of two areas:

Rev.01/01/02

- For text areas, graphic is placed on the left-most page margin.
- For matrix areas, graphic is placed on the right-most margin.

Rev.01/01/02

In addition, the following is a list of changes for the year 2001 with their page numbers and revision dates.

Revisions/Details

Date

Page 17, Highlights

- Added new bullet for “Encounter Indicator” 2/07/02
- Changed bullet for Provider ID length from nine digits to seven digits 4/08/02

Page 19, 01-Processor Data

- Added new field, 01-21.3, for “Encounter Indicator” 2/07/02

Page 28, 41-Claim Data Condition-Value

- Changed field 41-14 Field Req from “-” to “C” and added Comments 2/14/02
- Changed field 41-15 Field Req from “C” to “-” and deleted Comments 2/14/02
- Removed Medicare reference from field 41-21 6/19/02
- Added Medicare reference to field 41-27 6/19/02

Page 29, 41-Claim Data Condition-Value

- Changed field 41-29, added “Medicare Coinsurance Amount” to Comments 2/14/02

Page 36, 90-Claim Control Screen

- Changed field 90-17b, added “update with Action and Term Codes to Comments 2/14/02

Appendix

- Changed Payer codes to: “C-Medicare”, “D-Medicaid”, and “I-Other.” Deleted all other codes 6/19/02

Page 17, Highlights

- Added Bullet: “There is a maximum of 50 revenue codes allowed.” 2/11/03

Page 25, Changed Field No “34-14.3” to “31-14.3” 2/20/03

Page 1, Changed web address to [c](#) 3/10/03

Page 28, Field No. 41-14, under Field Def, changed “X(05)” to “9(05)” 4/25/03

Chapter 1 Introduction

ACS, a leader in health care technology, provides Gateway services to providers enrolled in contracted health care plans. Our electronic claims acquisition services provide an array of tools that allow you to:

- Easily submit all of your claims to one source
- Submit claims twenty-four hours a day, seven days a week
- Receive confirmation of receipt of each file transferred
- Receive payment from health care plans on a regular basis

Health care plans that participate with ACS are referred to as “payers.” Claims are accepted electronically into our data center in Tallahassee, Florida, and are processed through various electronic systems to payment. As a gateway service, we provide connectivity to various health care plans and states where ACS is the fiscal agent.

This manual outlines the procedures necessary for the transmission of electronic claims. It targets billing services and software vendors who are developing electronic claims submission capabilities for transmission to ACS.

Chapter 4 of this manual contains important payer-specific information required by ACS. The Consultec Clearinghouse System (CCHS) Requirements Matrix, which follows Chapter 4, details the records and fields required for claims processing.

This manual is intended to be used in conjunction with the national format specifications published by HCFA. These publications offer field-by-field breakdowns, definitions, and valid values. They can be accessed at <http://cms.hhs.gov/providers/edi/edi3.asp>. For UB92 claims, access the link to [UB92 Version 5.0 Flat File Format](#). For HCFA 1500 claims, access the link to [HCFA National Standard Format Version 3.01](#).

Rev.03/11/03

Chapter 2 Communications

ACS' EDI Gateway

ACS' EDI Gateway consists of an interactive, menu-driven bulletin board that allows you to upload your claim files and receive immediate confirmation of the status of your transfer. The EDI Gateway is accessed using a standard modem and supports modem speeds of up to 33,600 BPS.

Communication Protocols

ACS currently supports the following options:

- Async – XMODEM, YMODEM, ZMODEM, Kermit

Transmission Hours

Claims transmission is available twenty-four hours a day, seven days a week. This availability is subject to scheduled and unscheduled host downtime. It is operational policy to schedule preventative maintenance periods on weekends whenever possible.

Teleprocessing Requirements

The general specifications for communication with ACS are:

<i>Telecommunications</i>	Hayes-compatible 2400-33.6K BPS asynchronous modem
<i>File Format</i>	ASCII text data
<i>Compression Techniques</i>	PKZIP will compress one-to-many files in a single ZIP archive. Microsoft Compress will compress only a single file. GnuZip will compress only a single file. ARC (Archive) will compress one-to-many files in a single file. LHA or LHARC will compress one-to-many files in a single file. ACS accepts transmissions with any of the above compression techniques, as well as non-compressed files.
<i>Data Format</i>	8 data bit, 1 stop bit, no parity, full duplex
<i>Transmission Protocol</i>	ZMODEM uses 128 byte to 1024 byte variable packets and a 16-bit or 32-bit CRC (Cyclical Redundancy Check). XMODEM uses 128 byte blocks and a 16-bit CRC. YMODEM uses 1024 byte blocks and a 16-bit CRC. KERMIT can be accepted if X, Y, or ZMODEM capabilities are not available with your communication software.

Transmission Procedures

Calling System

1. *Dials ACS' HOST*
2. *Enters User Name & <CR>*
3. *Enters User Number & <CR>*
4. *Enter Desired Selection & <CR>*
5. *Enter "1" to send file & <CR>*

HOST System

Answers call, negotiates a common baud rate, and sends to the caller->

"Enter your User Name=>"

Receives User Name (Logon Name) and sends to the caller->

"Enter your User Number=>"

Receives User Number (Logon User ID) and verifies if caller is an authorized user.

Sends HOST selection menu followed by a user prompt->

"Please Enter Your Selection=>"

#1. Electronic Claim Submission: Assigns and sends the transmission file name, then waits for ZMODEM (by default) file transfer to be initiated by the caller.

#3. Select File Transfer Protocol: Allows submitter to change the protocol for the current submission only. The protocol may be changed to **(K)**ermit, **(X)**Modem, **(Y)**Modem, or **(Z)**Modem. Enter the first letter of the protocol that you wish to use.

#9. Exit & Disconnect: Terminates connection.

Receives ZMODEM (or other designated protocol) file transfer. Upon completion, initiates file confirmation. Sends file confirmation report.

Sends HOST selection menu followed by a user prompt=>

"Please Enter Your Selection=>"

6. Enter Desired Selection & <CR>

#1. Electronic Claim Submission: Assigns and sends the transmission file name, then waits for ZMODEM (by default) file transfer to be initiated by the caller.

#3. Select file Transfer Protocol: Allows submitter to change the protocol for the current transmission only.

#4. Download Confirmation: Allows submitter to download the confirmation report. See below for further explanation.

#9. Exit & Disconnect: Terminates connection.

Confirmation Reports

After the transmission is complete, a confirmation report describing the success or failure of the transmission is produced. The confirmation report will appear briefly on the monitor of the computer that is used to submit the data. You may download the report by selecting Option 4 (as outlined above). The file will be sent to the download directory of the communications software that is used for transmission. The file naming convention is line##.txt, with ## representing the last two digits of the file number assigned by ACS. For example, the name of the electronic confirmation report for file name 02010001.621 will be line21.txt.

The following is an example of a confirmation report. The first line indicates successful file transmission. The second line indicates a rejected transmission. Below the sample confirmation report is a detailed explanation of the components of a confirmation report. Please notify an EDI Business Analyst during the testing process if your communications package does not allow you to receive the confirmation report.

Date: 01/05/01	ACS Host System	Time: 07:02						
User Name: JANED		User Number: 123456789						
File Number	Payer	Frmt	Type	Claims	Batches	Tot. Charges	Status	Msg.
-----	-----	-----	-----	-----	-----	-----	-----	-----
06050001.609	77027	UB	UB92	1000	1	69500.00	PROD	001
06050001.609	77027	NSF	HCFA	100	1	2500.00	PROD	001
Messages								
001 – File Received								
** End of Report **								

Field Name

Explanation

Date

(MM/DD/YY) date transmission received

Time

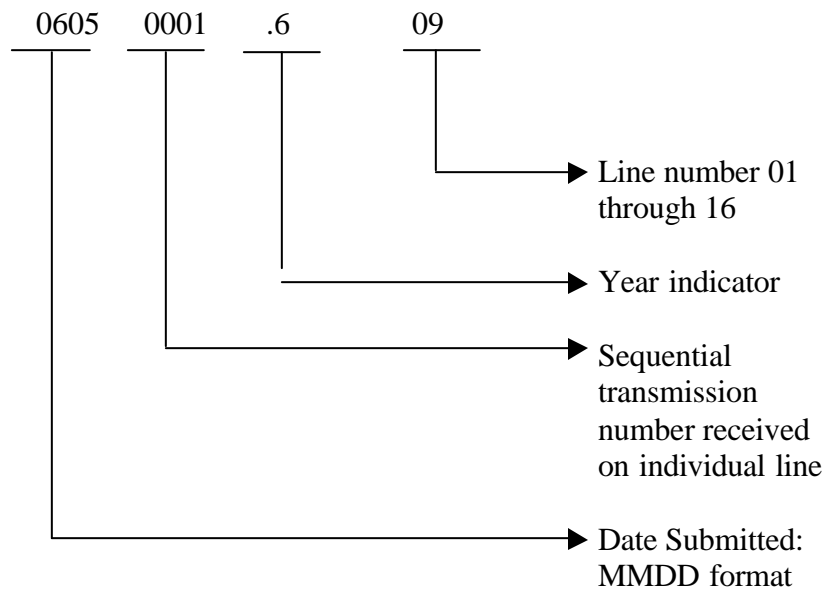
(HH:MM) time transmission received

User Name

Name that identifies the submitter to the host system

Communications

<u>Field Name</u>	<u>Explanation</u>
<i>User Number</i>	Number that allows the submitter access to the host system
<i>File Number</i>	(MMDDnnnn.x0n) tracking number for file receipt verification



<i>Payer</i>	Entity to receive the claims. Identified by a five-digit ID.
<i>Frmt</i>	Format. File structure of the logical files transmitted. "NSF" = National Standard Format, "UB" = Uniform Billing Format
<i>Type</i>	Claim type received. "HCFA" = HCFA 1500 claims, "DENT" = dental claims, "UB92" = Institutional Claims
<i>Claims</i>	Number of claims
<i>Batches</i>	Number of batches
<i>Tot. Charges</i>	Total charges

<u>Field Name</u>	<u>Explanation</u>
<i>Status</i>	Disposition of the file as determined by the host system. “Test” = file is processed as a test, “Prod” = file is processed as production, “Reject” = file is not accepted for processing and must be resubmitted, “Hold” = file is accepted but will not be processed
<i>Msg</i>	Message number. Reference the corresponding entry in the “Messages” area of the confirmation report for interpretation. Message numbers are assigned sequentially as files are processed. A “Msg” of 001 may not always imply the same condition. 001 is the first condition that occurred, 002 is the second condition that occurred, and so on
<i>Messages</i>	Explanation of the “Msg” field. Files that are not accepted have a status of “reject.” These files are not processed; they must be corrected and transmitted again by the submitter

Confirmation Messages

The following edits are applied to incoming transmissions before the confirmation report is generated. One or more of the following messages will be on the confirmation report if a condition is present.

<u>MESSAGE</u>	<u>DESCRIPTION</u>
<i>Invalid record length, Rec. 9999</i>	Specific to file format. Record indicated is too long or too short.
<i>Invalid (non-text) characters, Rec. 9999</i>	Record number indicated contains non-text characters. Sequence of control characters may be incorrect. Must have both a Carriage Return character and a Line Feed character at the end of every line. Must be a CR character (hex 0D) followed by a LF character (hex 0A).
<i>Invalid record sequence, Rec. 9999</i>	Record ID is incorrect. Refer to the record number indicated and its preceding record.
<i>User not approved for Payer/Format/Type</i>	File does not match criteria of submitter's enrollment. One (or more) of these fields is incorrect (Payer ID, file format, claim type).
<i>Number of detail recs exceeds maximum</i>	Number of line items exceeds the maximum allowed by the payer for this claim type.
<i>Unknown format/type</i>	File format and claim type could not be determined. Unable to accept the file.

MESSAGE

DESCRIPTION

Payer ID not found

Payer ID on the TPL record is spaces and Receiver ID on the header record is spaces. Unable to accept the claim(s).

Editor Off

Not a true error message. For information only. File accepted with no edits performed during communications link. No file statistics are returned to the submitter.

File received

File successfully transmitted and received.

Too many logical files in physical file

Current max of 500 logical files per physical file transmission.

Testing Procedures

You must complete the testing process before you can submit electronic claims for payment. ACS' EDI Business Analysts are available to assist you through the testing process. Each test transmission is inspected thoroughly to ensure that no format errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, we request that you send real claims data. The number of test transmissions required depends on the percentage of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to your software or ACS' host system.

Before testing, contact an EDI Business Analyst at 1-866-775-8563 to obtain a Vendor ID and test Logon Name and password. The Vendor ID, a five-digit alphanumeric code that must appear in the VENDOR ID field of the file header record, is used to identify the software that is being used to transmit claims.

When the testing process is complete and the software is approved, software vendors must send a client list to ACS. This list must detail the names and Submitter IDs of all clients who will use the approved software to submit electronic claims directly to ACS. All clients submitting claims for payment, including billing agents and clearinghouses, must be enrolled with ACS' EDI Support Unit. The EDI Support Unit will assign all direct submitters a Submitter ID, Logon Name, and Logon ID. Refer to Chapter 4 of this manual for the EDI Support Unit telephone number.

Testing Steps

Refer to “Transmission Procedures” in Chapter 2 for directions on using the Logon Name and Logon User ID. Each test transmission must contain ten to twenty claims. When the transmission is complete, select menu option 4 to receive a brief confirmation notice verifying receipt of the data or indicating that the transmission failed. A sample confirmation report and detailed instructions on interacting with the host menu system is located in Chapter 2 of this manual. If the transmission fails continuously, contact the EDI Business Analyst Unit.

ACS processes the data through several validation and reformatting programs. The resulting edit/error report is used to determine if problems exist with your record formats.

An EDI Business Analyst will determine if problems exist with the format and will contact you with the results of your test.

Chapter 4 Payer-Specific Data

EDI Support

The EDI Support Unit assists users with questions about electronic claims submission. ACS' EDI Support Unit is available to all District of Columbia Department of Health Medical Assistance Administration submitters and providers, Monday through Friday from 8:00 a.m. to 5:00 p.m. EST at 1-866-775-8563. The EDI Support Unit:

- Provides information on available services
- Enrolls users for claims submission
- Verifies receipt of electronic transmissions
- Provides technical assistance to users who are experiencing transmission difficulties

Enrollment Information

Clearinghouses, billing agents, and providers using self-programmed systems who will be sending electronic claims to ACS must complete an "EDI Enrollment Form." This form provides ACS the information necessary to assign a Logon Name, Logon ID, and Submitter ID, which are required to submit electronic claims. You can obtain a copy of this form by contacting the EDI Support Unit or by downloading it from our website at www.acs-gcro.com.

Transmission Telephone Number

ACS provides availability for claims transmission 24 hours a day, 7 days a week. There are no restrictions on the number of claims or the frequency of transmissions. The claims transmission telephone number is 1-800-334-2832 or 1-800-334-4650.

Tracking Transmission/Production Problems

Please have the following information available when calling the EDI Support Unit regarding transmission and production issues.

Submitter ID: Your Submitter ID is our key to accessing your submitter information. Please have this number available each time you contact the EDI Support Unit.

Logon Name and Logon User ID: These allow asynchronous submitters access to the host system for claims submission. The EDI Support Unit uses this information to reference your submitted data.

File Name: When inquiring about the receipt of a transmission, please have the host system file name available. The host system file name, unique to each transmission, is found on each confirmation report. An example and explanation of the host system file name is found in Chapter 2 of this manual.

Claims Edits

<i>Dates</i>	All dates must be numeric, valid dates												
<i>Records</i>	All records 192 characters in length. Records must follow the sequence dictated by the.												
<i>Fields</i>	<p>Numeric fields must be unsigned, right justified, zero-filled, and can only contain numeric characters (0-9).</p> <p>Alphanumeric fields must be left justified, space-filled, and can contain alpha (A-Z) and numeric (0-9) characters.</p>												
<i>Control Characters</i>	The sequence of control characters must be correct on every record. There must be a carriage return character and a line feed character at the end of every line.												
<i>Field Requirements</i>	<p>The FIELD REQ column on the CCHS Requirements Matrix uses these values:</p> <table><tr><td>R</td><td>Required</td><td>Record: Must send this record Field: Claim cannot be paid without this information.</td></tr><tr><td>C</td><td>Conditional</td><td>Under certain conditions, this information must be included for payment. See comments where necessary.</td></tr><tr><td>O</td><td>Optional</td><td>Does not affect processing.</td></tr><tr><td>-</td><td>Not Used</td><td>Not currently used.</td></tr></table>	R	Required	Record: Must send this record Field: Claim cannot be paid without this information.	C	Conditional	Under certain conditions, this information must be included for payment. See comments where necessary.	O	Optional	Does not affect processing.	-	Not Used	Not currently used.
R	Required	Record: Must send this record Field: Claim cannot be paid without this information.											
C	Conditional	Under certain conditions, this information must be included for payment. See comments where necessary.											
O	Optional	Does not affect processing.											
-	Not Used	Not currently used.											

Field Definition

The FIELD DEFINITION column on the CCHS Requirements Matrix uses standard COBOL methods for describing data.

X(02) = Where X denotes alphanumeric characters and 02 is the length of the data.

9(06) = Where 9 denotes numeric data and 06 is the length of the data

9(07)v99 = Where the v denotes an implied decimal. This is the method for describing amount fields. The value to the left indicates a seven-character field with no decimal. The last two characters in the field represent the cents associated with the amount. The total length of this field is nine characters with no decimal.

Sequence of Records

ACS accepts version 050 of the National Uniform Billing Committee (NUBC) UB92 format. The format, outlined by the NUBC matrix, allows users to send data to multiple payers in the same format. This format also allows Payers the capability of data element customization within the standardized format.

The sequence of file records identifies the order of the records, the type of record and record name, and the record requirement.

Record Type		Requirement
01	Processor Data	R
	10 Provider Data	R
	20 Patient Data	R
	30 Third Party Payer Data	R
	31 Third Party Payer Data	R
	40 Claim Data TAN-Occurrence	R
	41 Claim Data Condition – Value	C
	50 IP Accommodations Data	C (R on Inpatient)
	60 IP Ancillary Services Data	C
	61 Outpatient Procedures	C (R on Outpatient)
	70 Medical Data	R
	80 Physician Data	R
	90 Claim Control Screen	R
	92 Claim Control Totals	C (R on Crossover Claims only)
	95 Provider Batch Control	R
99	File Control	R

There are many fields required by ACS in the UB92 format. You must code to the full UB92 specifications and include all required fields in order to expect correct claim processing.

Highlights

To promote efficient, accurate electronic claims processing, please note:

- The Receiver ID and Payer ID for the District of Columbia is **77033**. Transmissions without this value in the appropriate fields will not be processed.
- Users are assigned a five-digit Submitter ID.
- All dates are in the CCYYMMDD format.
- The same phone number will be used for transmitting test and production.
- The District of Columbia Provider ID's are nine digits.
- Fields marked as "Required" are required for all claim types unless otherwise noted.
- Encounter Indicator "01-21.3" is required for all encounter claims. Valid values include "E" for Encounter claims and Space for Other.
- There is a maximum of 50 revenue codes allowed.

Rev.04/08/02

Rev.02/07/02

Rev.02/11/03

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

VERSION 5

01-Processor Data

RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
01-01	Record Type	X(02)	01	02	R	Valid value is ‘01.’
01-02	Submitter EIN	9(10)	03	12	R	
01-03	Multiple Provider Billing File Indicator	9(01)	13	13	R	1 = Single Provider 2 = Multiple Providers
01-04	Filler	X(17)	14	30	-	SPACES
01-05	Receiver Type Code	X(01)	31	31	R	D = Medicaid
01-06	Receiver Identification	9(05)	32	36	R	Valid value is 77033
01-07	Receiver Sub-Identification	X(04)	37	40	-	
01-08	Filler	9(06)	41	46	-	SPACES
01-09	Submitter Name	X(21)	47	67	R	
01-10	Submitter Address	X(18)	68	85	R	
01-11	Submitter City	X(15)	86	100	R	
01-12	Submitter State	X(02)	101	102	R	
01-13	Submitter Zip Code	X(09)	103	111	R	
01-14	Submitter Fax	9(10)	112	121	O	
01-15	Country Code	X(04)	122	125	-	
01-16	Submitter Telephone Number	9(10)	126	135	R	
01-17	File Sequence & Serial Number	X(07)	136	142	O	
01-18	Test/Production Indicator	X(04)	143	146	-	
01-19	Date of Receipt	9(8)	147	154	-	CCYYMMDD
01-20	Processing Date	9(8)	155	162	R	CCYYMMDD

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

VERSION 5

01-Processor Data

RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
01-21	FILLER – Redefined by ACS				
01-21.1	Submitter ID	9(5)	163 167	R	Five-digit ID assigned by ACS.
01-21.2	Vendor ID	X(05)	168 172	C	Five-digit ID assigned by ACS. Required for vendors.
01-21.3	Encounter Ind	X(01)	173 173	C	“E” for Encounter claims and Space for Other. <small>Rev.02/07/02</small>
01-21.4	FILLER	X(16)	174 189	R	
01-22	Version Code	X(03)	190 192	R	Valid value is 050. File will reject if invalid

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

VERSION 5

10-Provider Data

RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
10-01	Record Type	X(02)	01 02	R	Valid value is "10."
10-02	Type of Batch	X(03)	03 05	R	
10-03	Batch Number	9(02)	06 07	R	
10-04	Federal Tax Number or EIN	9(10)	08 17	R	
10-05	Federal Tax Sub ID	X(04)	18 21	-	
10-06	National Provider ID	X(13)	22 34	C	Required for crossover claims. Enter Medicare Provider Number.
10-07	Medicaid Provider Number	X(13)	35 47	R	District of Columbia Provider ID. Must be nine numeric characters.
10-08	CHAMPUS Insurer Provider Number	X(13)	48 60	-	
10-09	Other Insurer Provider Number – 1	X(13)	61 73	-	
10-10	Other Insurer Provider Number – 2	X(13)	74 86	-	
10-11	Provider Telephone Number	9(10)	87 96	R	
10-12	Provider Name	X(25)	97 121	R	
10-13	Provider Address	X(25)	122 146	R	
10-14	Provider City	X(14)	147 160	R	
10-15	Provider State	X(02)	161 162	R	
10-16	Provider ZIP Code	X(09)	163 171	R	
10-17	Provider FAX Number	9(10)	172 181	R	
10-18	Country Code	X(04)	182 185	-	
10-19	Filler	X(04)	186 189	-	SPACES
10-20	Filler	X(03)	190 192	-	SPACES

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

VERSION 5

20-Patient Data

RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
20-01	Record Type	X(02)	1	2	R	Valid value is “20.”
20-02	Filler (National Use)	X(02)	3	4	-	SPACES
20-03	Patient Control Number	X(20)	5	24	R	Must be the same on each record within a claim (20-90 record set)
20-04	Patient Last Name	X(20)	25	44	R	
20-05	Patient First Name	X(09)	45	53	R	
20-06	Patient Middle Initial	X(01)	54	54	O	
20-07	Patient Sex	X(01)	55	55	O	
20-08	Patient Birthdate	9(08)	56	63	O	CCYYMMDD
20-09	Patient Marital Status	X(01)	64	64	O	
20-10	Type of Admission	X(01)	65	65	C	Required on inpatient claims
20-11	Source of Admission	X(01)	66	66	C	Required on inpatient claims
20-12	Patient Address - Line 1	X(18)	67	84	O	
20-13	Patient Address - Line 2	X(12)	85	96	O	
20-14	Patient City	X(15)	97	111	O	
20-15	Patient State	X(02)	112	113	O	
20-16	Patient ZIP Code	X(09)	114	122	O	
20-17	Admit / Start of Care Date	9(08)	123	130	C	Required on inpatient claims – CCYYMMDD
20-18	Admission Hour	X(02)	131	132	C	Required on inpatient claims
20-19	Statement Covers From	9(08)	133	140	R	CCYYMMDD
20-20	Statement Covers Thru	9(08)	141	148	R	CCYYMMDD
20-21	Patient Status	9(02)	149	150	C	Required on inpatient claims

CCHS REQUIREMENTS MATRIX – UB92

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VERSION 5

20-Patient Data

RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
20-22	Discharge Hour	X(02)	151 152	C	Required on inpatient claims
20-23	Payments Received (Patient line)	9(8)v99	153 162	O	
20-24	Estimated Amount Due (Patient line)	9(8)v99	163 172	O	
20-25	Medical Record Number	X(17)	173 189	O	
20-26	Filler (National Use)	X(03)	190 192	-	SPACES

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

VERSION 5

30-Third Party Payer Data

RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
30-01	Record Type	X(02)	1	2	R	Valid value is “30.”
30-02	Sequence Number	9(02)	3	4	R	
30-03	Patient Control Number	X(20)	5	24	R	
30-04	Source of Payment Code	X(01)	25	25	R	Valid value is “D” = Medicaid
30-05	Payer Identification	X(05)	26	30	R	Valid value is “77033.”
30-06	Payer Sub-Identification	X(04)	31	34	-	
30-07	Insured’s ID Number	X(19)	35	53	R	Enter the Medicaid recipient ID
30-08a	Payer Identification Indicator	X(02)	54	55	-	
30-08b	Payer Name	X(23)	56	78	R	District of Columbia
30-09	Payer Code	X(01)	79	79	O	
30-10	Insurance Group Number	X(17)	80	96	O	
30-11	Insured Group Name	X(14)	97	110	O	
30-12	Insured’s Last Name	X(20)	111	130	O	
30-13	Insured’s First Name	X(09)	131	139	O	
30-14	Insured’s Middle Initial	X(01)	140	140	O	
30-15	Insured’s Sex	X(01)	141	141	O	
30-16	Release of Information Certification Indicator	X(01)	142	142	-	
30-17	Assignment of Benefits Certification Indicator	X(01)	143	143	-	
30-18	Patient’s Relationship to Insured	9(02)	144	145	O	
30-19	Employment Status Code	9(01)	146	146	C	Used only on crossovers. Optional field.

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

VERSION 5

30-Third Party Payer Data

RECORD REQUIRED

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
30-20	Covered Days	9(03)	147	149	C	Required for inpatient.
30-21	Noncovered Days	9(04)	150	153	C	Required for inpatient.
30-22	Coinsurance Days	9(03)	154	156	O	
30-23	Lifetime Reserve Days	9(03)	157	159	O	
30-24	Provider Identification No	X(13)	160	172	R	District of Columbia Provider ID. Must be nine numeric characters.
30-25	Payments Received	9(08)v99	173	182	O	
30-26	Estimated Amount Due	9(08)v99	183	192	-	

CCHS REQUIREMENTS MATRIX – UB92

**District of Columbia
31-Third Party Payer Data**

**VERSION 5
RECORD REQUIRED**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
31-01	Record Type	X(02)	1	2	R	Valid value is “31.”
31-02	Sequence Number	9(02)	3	4	R	
31-03	Patient Control Number	X(20)	5	24	R	
31-04	Insured’s Address - Line 1	X(18)	25	42	O	
31-05	Insured’s Address - Line 2	X(12)	43	54	O	
31-05A	Filler	X(06)	55	60	-	SPACES
31-06	Insured’s City	X(15)	61	75	O	
31-07	Insured’s State	X(02)	76	77	O	
31-08	Insured’s ZIP Code	X(09)	78	86	O	
31-09	Employer Name	X(24)	87	110	-	
31-10	Employer Address	X(18)	111	128	-	
31-11	Employer City	X(15)	129	143	-	
31-12	Employer State	X(02)	144	145	-	
31-13	Employer ZIP Code	X(09)	146	154	-	
31-14	Form Locator 37 (ICN/DCN)	X(23)	155	177	C	
31-14.1	TCN to credit	X(17)	155	171	C	
31-14.2	Adjustment reason	X(02)	172	173	C	
31-14.3	Filler	X(04)	174	177	R	Rev.02/2003
31-15	Contract Number	X(05)	178	182	-	
31-16	Filler (National Use)	X(10)	183	192	-	SPACES

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

40-Claim Data TAN-Occurrence

**VERSION 5
RECORD REQUIRED**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
40-01	Record Type	X(02)	1	2	R	Valid value is “40.”
40-02	Sequence Number	9(02)	3	4	R	
40-03	Patient Control Number	X(20)	5	24	R	
40-04	Type of Bill	X(03)	25	27	R	
40-05	Treatment Authorization Code-A	X(18)	28	45	O	
40-06	Treatment Authorization Code-B	X(18)	46	63	O	
40-07	Treatment Authorization Code-C	X(18)	64	81	-	
40-08	Occurrence Code – 1	X(02)	82	83	C	
40-09	Occurrence Date - 1	9(08)	84	91	C	CCYYMMDD
40-10	Occurrence Code – 2	X(02)	92	93	C	
40-11	Occurrence Date - 2	9(08)	94	101	C	CCYYMMDD
40-12	Occurrence Code – 3	X(02)	102	103	C	
40-13	Occurrence Date - 3	9(08)	104	111	C	CCYYMMDD
40-14	Occurrence Code – 4	X(02)	112	113	C	
40-15	Occurrence Date - 4	9(08)	114	121	C	CCYYMMDD
40-16	Occurrence Code – 5	X(02)	122	123	C	
40-17	Occurrence Date - 5	9(08)	124	131	C	CCYYMMDD
40-18	Occurrence Code – 6	X(02)	132	133	C	
40-19	Occurrence Date - 6	9(08)	134	141	C	CCYYMMDD
40-20	Occurrence Code – 7	X(02)	142	143	C	
40-21	Occurrence Date - 7	9(08)	144	151	C	CCYYMMDD
40-22	Occurrence Span Code – 1	X(02)	152	153	C	

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

40-Claim Data TAN-Occurrence

**VERSION 5
RECORD REQUIRED**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
40-23	Occurrence Span From Date – 1	9(08)	154 161	C	CCYYMMDD
40-24	Occurrence Span Thru Date – 1	9(08)	162 169	C	CCYYMMDD
40-25	Occurrence Span Code – 2	X(02)	170 171	C	
40-26	Occurrence Span From Date – 2	9(08)	172 179	C	CCYYMMDD
40-27	Occurrence Span Thru Date – 2	9(08)	180 187	C	CCYYMMDD
40-28	Filler	X(05)	188 192	-	

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

41-Claim Data Condition – Value

**VERSION 5
RECORD CONDITIONAL**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
41-01	Record Type	X(02)	1	2	R	Valid value is “41.”
41-02	Sequence Number	9(02)	3	4	R	
41-03	Patient Control Number	X(20)	5	24	R	
41-04	Condition Code – 1	X(02)	25	26	O	
41-05	Condition Code – 2	X(02)	27	28	O	
41-06	Condition Code – 3	X(02)	29	30	O	
41-07	Condition Code – 4	X(02)	31	32	O	
41-08	Condition Code – 5	X(02)	33	34	O	
41-09	Condition Code – 6	X(02)	35	36	O	
41-10	Condition Code – 7	X(02)	37	38	O	
41-11	Condition Code - 8	X(02)	39	40	-	
41-12	Condition Code - 9	X(02)	41	42	-	
41-13	Condition Code - 10	X(02)	43	44	-	
41-14	Form Locator 31 (upper)	9(05)	45	49	C	Birth weight; measured in grams. Rev.04/25/02 Rev.02/14/02
41-15	Form Locator 31 (lower)	X(06)	50	55	-	Rev.02/14/02
41-16	Value Code - 1	X(02)	56	57	C	Used on crossovers
41-17	Value Amount - 1	9(07)v99	58	66	C	Used on crossovers
41-18	Value Code - 2	X(02)	67	68	C	Used on crossovers
41-19	Value Amount - 2	9(07)v99	69	77	C	Used on crossovers
41-20	Value Code - 3	X(02)	78	79	C	Used on crossovers
41-21	Value Amount - 3	9(07)v99	80	88	C	Used on crossovers Rev.06/19/02 Rev.02/14/02
41-22	Value Code - 4	X(02)	89	90	C	Used on crossovers

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

41-Claim Data Condition – Value

**VERSION 5
RECORD CONDITIONAL**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
41-23	Value Amount - 4	9(07)v99	91	99	C	Used on crossovers
41-24	Value Code - 5	X(02)	100	101	C	Used on crossovers
41-25	Value Amount - 5	9(07)v99	102	110	C	Used on crossovers
41-26	Value Code - 6	X(02)	111	112	C	Used on crossovers
41-27	Value Amount - 6	9(07)v99	113	121	C	Used on crossovers
41-28	Value Code - 7	X(02)	122	123	C	Used on crossovers
41-29	Value Amount - 7	9(07)v99	124	132	C	Used on crossovers;
41-30	Value Code - 8	X(02)	133	134	C	Used on crossovers
41-31	Value Amount - 8	9(07)v99	135	143	C	Used on crossovers
41-32	Value Code - 9	X(02)	144	145	-	
41-33	Value Amount - 9	9(07)v99	146	154	-	
41-34	Value Code - 10	X(02)	155	156	-	
41-35	Value Amount - 10	9(07)v99	157	165	-	
41-36	Value Code - 11	X(02)	166	167	-	
41-37	Value Amount - 11	9(07)v99	168	176	-	
41-38	Value Code - 12	X(02)	177	178	-	
41-39	Value Amount - 12	9(07)v99	179	187	-	
41-40	Filler (National Use)	X(05)	188	192	-	Used on crossovers

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

50-IP Accommodations Data

VERSION 5

**RECORD CONDITIONAL (REQUIRED
ON INPATIENT)**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
50-01	Record Type	X(02)	1	2	R	Valid value is "50."
50-02	Sequence Number	9(02)	3	4	R	
50-03	Patient Control Number	X(20)	5	24	R	
	Accommodations - 1	X(42)	25	66		
50-04	Accommodations Revenue Code	9(04)	25	28	R	
50-05	Accommodations Rate	9(07)v99	29	37	O	
50-06	Accommodations Days	9(04)	38	41	R	
50-07	Accommodations Total Charges	9(08)v99	42	51	R	
50-08	Accommodations Noncovered Charges	9(08)v99	52	61	O	
50-09	Form Locator 49	X(04)	62	65	-	
50-10	Filler (National Use)	X(01)	66	66	-	SPACES
50-11	Accommodations - 2	X(42)	67	108	C	
50-12	Accommodations - 3	X(42)	109	150	C	
50-13	Accommodations - 4	X(42)	151	192	C	

CCHS REQUIREMENTS MATRIX – UB92

**District of Columbia
60 – IP Ancillary Services Data**

**VERSION 5
RECORD CONDITIONAL**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
60-01	Record Type	X(02)	1	2	R	Valid value is “60.”
60-02	Sequence Number	9(02)	3	4	R	
60-03	Patient Control Number	X(20)	5	24	R	
	Inpatient Ancillaries - 1	X(56)	25	80		
60-04	Inpatient Ancillary Revenue Code	9(04)	25	28	R	
60-05	HCPCS Procedure Code/HIPPS	X(05)	29	33	O	
60-06	Modifier 1 (HCPCS & CPT-4)	X(02)	34	35	C	
60-07	Modifier 2 (HCPCS & CPT-4)	X(02)	36	37	C	
60-08	Inpatient Ancillary Units of Service	9(07)	38	44	R	
60-09	Inpatient Ancillary Total Charges	9(8)v99	45	54	R	
60-10	Inpatient Ancillary Noncovered Charges	9(8)v99	55	64	O	
60-11	Form Locator 49	X(04)	65	68	-	
60-12	Assessment Date	X(08)	69	76	-	CCYYMMDD
60-12a	Filler (National Use)	X(04)	77	80	-	SPACES
60-13	Inpatient Ancillaries - 2	X(56)	81	136	C	
60-14	Inpatient Ancillaries - 3	X(56)	137	192	C	

CCHS REQUIREMENTS MATRIX – UB92

District of Columbia

VERSION 5

61 – Outpatient Procedures

RECORD CONDITIONAL (REQUIRED ON OUTPATIENT)

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u> <u>TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
61-01	Record Type	X(02)	1 2	R	Valid value is “61.”
61-02	Sequence Number	9(02)	3 4	R	
61-03	Patient Control Number	X(20)	5 24	R	
	Revenue Center - 1	X(56)	25 80		
61-04	Revenue Center Code	9(04)	25 28	R	
61-05	HCPCS Procedure Code	X(05)	29 33	R	
61-06	Modifier 1 (HCPCS & CPT-4)	X(02)	34 35	C	
61-07	Modifier 2 (HCPCS & CPT-4)	X(02)	36 37	C	
61-08	Units of Service	9(07)	38 44	R	
61-09	Form Locator 49	X(06)	45 50	-	
61-10	Outpatient Total Charges	9(08)v99	51 60	R	
61-11	Outpatient Noncovered Charges	9(08)v99	61 70	O	
61-12	Date of Service	9(08)	71 78	O	CCYYMMDD
61-13	Filler (National Use)	X(02)	79 80	-	SPACES
61-14	Revenue Center - 2	X(56)	81 136	C	
61-15	Revenue Center - 3	X(56)	137 192	C	

CCHS REQUIREMENTS MATRIX – UB92

**District of Columbia
70 - Medical Data**

**VERSION 5
RECORD REQUIRED**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
70-01	Record Type	X(02)	1	2	R	Valid value is “70.”
70-02	Sequence	9(02)	3	4	R	
70-03	Patient Control Number	X(20)	5	24	R	
70-04	Principal Diagnosis Code	X(06)	25	30	R	
70-05	Other Diagnosis Code – 1	X(06)	31	36	O	
70-06	Other Diagnosis Code – 2	X(06)	37	42	O	
70-07	Other Diagnosis Code – 3	X(06)	43	48	O	
70-08	Other Diagnosis Code – 4	X(06)	49	54	O	
70-09	Other Diagnosis Code – 5	X(06)	55	60	O	
70-10	Other Diagnosis Code - 6	X(06)	61	66	O	
70-11	Other Diagnosis Code - 7	X(06)	67	72	O	
70-12	Other Diagnosis Code - 8	X(06)	73	78	O	
70-13	Principal Procedure Code	X(07)	79	85	C	
70-14	Principal Procedure Date	9(08)	86	93	C	CCYYMMDD
70-15	Other Procedure Code - 1	X(07)	94	100	C	
70-16	Other Procedure Date - 1	9(08)	101	108	C	CCYYMMDD
70-17	Other Procedure Code – 2	X(07)	109	115	C	
70-18	Other Procedure Date - 2	9(08)	116	123	C	CCYYMMDD
70-19	Other Procedure Code - 3	X(07)	124	130	C	
70-20	Other Procedure Date - 3	9(08)	131	138	C	CCYYMMDD
70-21	Other Procedure Code - 4	X(07)	139	145	C	
70-22	Other Procedure Date - 4	9(08)	146	153	C	CCYYMMDD

CCHS REQUIREMENTS MATRIX – UB92

**District of Columbia
70 - Medical Data**

**VERSION 5
RECORD REQUIRED**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
70-23	Other Procedure Code - 5	X(07)	154 160	C	
70-24	Other Procedure Date – 5	9(08)	161 168	C	CCYYMMDD
70-25	Admitting Diagnosis Code	X(06)	169 174	O	
70-26	External Cause of Injury (E-Code)	X(06)	175 180	O	
70-27	Procedure Coding Method Used	9(01)	181 181	-	
70-28	Filler (National Use)	X(11)	182 192	-	SPACES

CCHS REQUIREMENTS MATRIX – UB92

**District of Columbia
80 – Physician Data**

**VERSION 5
RECORD REQUIRED**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
80-01	Record Type	X(02)	1	2	R	Valid value is “80.”
80-02	Sequence	9(02)	3	4	R	
80-03	Patient Control Number	X(20)	5	24	R	
80-04	Physician Number Qualifying Codes	X(02)	25	26	C	
80-05	Attending Physician Number	X(16)	27	42	R	Attending Provider Number
80-06	Operating Physician Number	X(16)	43	58	-	
80-07	Other Physician Number	X(16)	59	74	O	Performing Provider Number
80-08	Other Physician Number	X(16)	75	90	-	
80-09	Attending Physician Name	X(25)	91	115	-	
80-10	Operating Physician Name	X(25)	116	140	-	
80-11	Other Physician Name	X(25)	141	165	-	
80-12	Other Physician Name	X(25)	166	190	-	
80-13	Filler (National Use)	X(02)	191	192	-	SPACES

CCHS REQUIREMENTS MATRIX – UB92

**District of Columbia
90 – Claim Control Screen**

**VERSION 5
RECORD REQUIRED**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
90-01	Record Type	X(02)	1	2	R	Valid value is “90.”
90-02	Filler (National Use)	X(02)	3	4	-	SPACES
90-03	Patient Control Number	X(20)	5	24	R	
90-04	Physical Record Count (Excluding RT 90 + 91)	9(03)	25	27	R	
90-05	Record Type 2n Count	9(02)	28	29	R	
90-06	Record Type 3n Count	9(02)	30	31	R	
90-07	Record Type 4n Count	9(02)	32	33	R	
90-08	Record Type 5n Count	9(02)	34	35	R	
90-09	Record Type 6n Count	9(02)	36	37	R	
90-10	Record Type 7n Count	9(02)	38	39	R	
90-11	Record Type 8n Count	9(02)	40	41	R	
90-12	Record Type 91 Qualifier	9(01)	42	42	C	
90-13	Total Accommodation Charges Revenue Centers	9(08)v99	43	52	R	
90-14	Noncovered Accommodation Charges – Revenue Centers	9(08)v99	53	62	R	
90-15	Total Ancillary Charges Revenue Centers	9(08)v99	63	72	R	
90-16	Noncovered Ancillary Charges-Revenue Centers	9(08)v99	73	82	R	
90-17	Redefined by ACS					
90-17.1	Level of Care	X(01)	83	83	C	Required on LTC claims
90-17.2	Termination Care	X(01)	84	84	C	
90-17.3	Action Code	X(01)	85	85	C	LTC Claims A=Admission, D=Discharge
90-17.4	Remarks	X(107)	86	192	-	Spaces

CCHS REQUIREMENTS MATRIX – UB92

**District of Columbia
92 Claim Control Totals**

**VERSION 5
RECORD CONDITIONAL**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM</u>	<u>POSITION TO</u>	<u>FIELD REQ</u>	<u>COMMENTS</u>
92-01	Record Type	X(02)	1	2	R	Valid value is “92.” Required for crossover claims.
92-02	Sequence Number	9(02)	3	4	-	
92-03	Patient Control Number	X(20)	5	24	-	
92-04	Current DCN/ICN	X(23)	25	47	-	
92-05	FILLER	X(06)	48	53	R	
92-06	Total Submitted Charges	9(08)v99	54	63	-	
92-07	Total Non-covered Charges	9(08)v99	64	73	-	
92-08	Total Charge Allowed	9(08)v99	74	83	R	
92-09	Total Medicare Reimbursement	9(08)v99	84	93	-	
92-10	Total Amount Medicare Paid Provider	9(08)v99	94	103	R	
92-11	Total Amount Medicare Paid Beneficiary	9(08)v99	104	113	-	
92-12	Total Medicare Days Utilized	9(04)	114	117	-	
92-13	DRG Assigned via Grouper	9(03)	118	120	-	
92-14	DRG Amount Applied via Pricer	9(08)v99	121	130	-	
92-15	DRG Outlier Amount	9(08)v99	131	140	-	
92-16	Total Denied Charges	9(08)v99	141	150	-	
92-17	Cost Report Days	9(03)	151	153	-	
92-18	Lifetime Psychiatric Days	9(03)	154	156	-	
92-19	Claim Status	X(02)	157	158	-	

CCHS REQUIREMENTS MATRIX – UB92

**District of Columbia
92 Claim Control Totals**

**VERSION 5
RECORD CONDITIONAL**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
92-20	Reimbursement Rate (%)	9(04)v999	159	165	-	
92-21	Claim paid date	9(08)	166	173	R	CCYYMMDD
92-22	Filler	X(19)	174	192	R	

CCHS REQUIREMENTS MATRIX – UB92

**District of Columbia
95 Provider Batch Control**

**VERSION 5
RECORD REQUIRED**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
95-01	Record Type	X(02)	1	2	R	Valid value is “95.”
95-02	Federal Tax Number (EIN)	9(10)	3	12	R	
95-03	Receiver Identification	9(05)	13	17	R	Valid value is “77033.”
95-04	Receiver Sub-Identification	X(04)	18	21	-	
95-05	Type of Batch	X(03)	22	24	R	
95-06	Number of Claims	9(06)	25	30	R	
95-07	Filler (National Use)	X(06)	31	36	-	SPACES
95-08	Accommodations Total Charges for the Batch	9(10)v99	37	48	R	
95-09	Accommodations Noncovered Charges for the Batch	9(10)v99	49	60	R	
95-10	Ancillary Total Charges for the Batch	9(10)v99	61	72	R	
95-11	Ancillary Noncovered Charges for the Batch	9(10)v99	73	84	R	
95-12	Filler (National Use)	X(54)	85	138	-	SPACES
95-13	Filler (Local Use)	X(54)	139	192	-	SPACES

CCHS REQUIREMENTS MATRIX – UB92

**District of Columbia
99 File Control**

**VERSION 5
RECORD REQUIRED**

<u>FIELD NO</u>	<u>FIELD NAME</u>	<u>FIELD DEF</u>	<u>POSITION FROM TO</u>		<u>FIELD REQ</u>	<u>COMMENTS</u>
99-01	Record Type	X(02)	1	2	R	Valid value is “99.”
99-02	Submitter EIN	9(10)	3	12	R	
99-03	Receiver Identification	9(05)	13	17	R	Valid value is “77033.”
99-04	Receiver Sub-Identification	X(04)	18	21	-	
99-05	Number of Batches Billed this File	9(04)	22	25	R	
99-06	Accommodations Total Charges for the File	9(11)v99	26	38	R	
99-07	Accommodations Noncovered Charges for the File	9(11)v99	39	51	R	
99-08	Ancillary Total Charges for the File	9(11)v99	52	64	R	
99-09	Ancillary Noncovered Charges for the File	9(11)v99	65	77	R	
99-10	Filler (National Use)	X(58)	78	135	-	SPACES
99-11	Filler (Local Use)	X(57)	136	192	-	SPACES

Appendix A Valid Values

Payer Codes:

C – Medicare

D – Medicaid

I – Other