

Current Export for Medical Fee Provider								
File Header Segment (Mandatory)								
Field #	Position	Length	Description	Comment	Requirements	Requirements Description		
1	1	2	Record Indicator	Literal "00"	Mandatory			
2	3	42	Filler	Blanks	Mandatory	Blanks for Header Segment		
3	43	51	Filler	Blanks	Mandatory	Blanks for Header Segment		
4	52	151	File Name	Import File Name	Optional	Can be blank		
5	152	161	Customer Number	CorVel MedCheck business unit number	Optional			
6	162	211	Customer Name	CorVel MedCheck business unit name	Optional			
	212	300	Filler	Filler				
Claim Segment (Mandatory)								
Field #	Position	Length	Description	Comment	Requirements	Requirements Description		
1	1	2	Record Indicator	Literal "01"	Mandatory			
2	3	42	Claim Number	Customer Claim Number	Mandatory*	*Mandatory for Non-MSP Services		
3	43	45	Claimant Number	Claim Claimant Number	Optional	Required for Auto*		
4	46	51	Filler	Filler	Blank			
5	52	53	State	Jurisdiction State	Mandatory*	<i>*Mandatory for Non-MSP Services, MSP Reporting item #15 in '80' record</i>		
6	54	63	Date of Injury	MM/DD/CCYY	Mandatory*	<i>*Mandatory for Non-MSP Services, MSP Reporting item #13 in '80' record</i>		
7	64	64	Minor Med	Minor Medical Indicator	Optional			
8	65	79	Carrier Number	Carrier Number	Optional			
9	80	82	LOB Code	Line of Business Code (AU, WC, GH, etc...)	Mandatory*	*Mandatory for Non-MSP Services		
10	83	87	Filler	Filler	Blank	(old adjuster id)		
11	88	95	Additional Ref	Used for mapping claims to CorVel Business Units	Optional			
12	96	125	Policy Holder	Policy holder's name	Optional			
13	126	126	Claim Status	("O"pen, "C"losed, "R"eopen, "D"elete, "X" Converted)	Optional			
14	127	136	CloseDate	Date Claim Closed (MM/DD/CCYY)	Optional			
15	137	236	Claim Comment	Comment	Optional			
16	237	256	StateClaimId	State Claim Id	Optional			
17	257	257	MPN Flag	MPN Flag	Optional			
18	258	267	Date MPN Eligible	MPN Eligible Date	Optional			
19	268	297	Adjuster ID	Adjuster ID	Optional	Mandatory for e-Roster		
20	298	298	MSP Status	Medicare Secondary Payer Status (0 = Non-MSP Participant Only, 1 = MSP Participant Only, 2 = Both (MSP Participant and Participant of Other Services)	Mandatory	NOTE: If the MSP reporting records are NOT going to be included, this field MUST contain a "0".		
21	299	299	CCRx Print Flag	Y - Print CCRx Card \ N - Do NOT print CCRx Card	Optional			
22	300	300	Filler	Filler				
Claim Segment 2 (Optional)								
Field #	Position	Length	Description	Comment	Requirements	Requirements Description		

1	1	2	2	Record Indicator	Literal "1A"	Mandatory	
2	3	42	40	Claim Number	Customer Claim Number	Mandatory*	*Mandatory for Non-MSP Services
3	43	45	3	Claimant Number	Claimant Number	Optional	Required for Auto*
4	46	51	6	Filler	Filler	Blank	
5	52	52	1	TX Certification Flag	Y - For Certified \ N - Not Certified	Optional	
6	53	62	10	TX Certification Effective Date	MM/DD/CCYY	Optional	
7	63	72	10	TX Certification Termination Date	MM/DD/CCYY	Optional	
8	73	300	228	Filler	Filler		
<b>Patient Segment (Mandatory)</b>							
<b>Field #</b>	<b>Position</b>	<b>Length</b>	<b>Description</b>	<b>Comment</b>	<b>Requirements</b>	<b>Requirements Description</b>	
1	1	2	2	Record Indicator	Literal "02"	Mandatory	
2	3	42	40	Claim Number	Customer Claim Number	Mandatory*	*Mandatory for Non-MSP Services
3	43	45	3	Claimant Number	Claimant Number	Optional	Required for Auto*
4	46	51	6	Filler	Filler	Blank	
5	52	71	20	Last Name	Patient Last Name	Mandatory*	<i>*Mandatory for Non-MSP Services, MSP Reporting item #7 in '80' record</i>
6	72	91	20	First Name	Patient First Name	Mandatory*	<i>*Mandatory for Non-MSP Services, MSP Reporting item #8 in '80' record</i>
7	92	111	20	Middle Name	Patient Middle Name	Optional	<i>MSP Reporting item #9 in '80' record</i>
8	112	121	10	Date of Birth	MM/DD/CCYY	Optional	<i>MSP Reporting item #11 in '80' record</i>
9	122	122	1	Gender	Patient gender	Optional	<i>MSP Reporting item #10 in '80' record</i>
10	123	131	9	SSN	Patient SSN	Optional	<i>MSP Reporting item #6 in '80' record</i>
11	132	140	9	Alien ID Number	Patient alien ID number	Optional	
12	141	190	50	Address Line 1	Patient address line 1	Optional	
13	191	240	50	Address Line 2	Patient address line 2	Optional	
14	241	270	30	City	Patient city	Optional	
15	271	272	2	State	Patient state	Optional	
16	273	281	9	Zip	Patient zip	Optional	
17	282	283	2	Loss Coverage	Loss coverage code	Optional	
18	284	285	2	Body Part	Injured body part	Optional	
19	286	287	2	Loss Nature	Nature of loss	Optional	
20	288	289	2	Loss Cause	Cause of loss	Optional	
21	290	290	1	Body Side	Side of body injured	Optional	
22	291	300	10	MMI Date (MM/DD/YYYY)	Maximum Medical Improvement Date	Optional	MM/DD/YYYY

				<b>Employer Segment (Optional)</b>			
<b>Field #</b>	<b>Position</b>	<b>Length</b>	<b>Description</b>	<b>Comment</b>	<b>Requirements</b>	<b>Requirements Description</b>	
1	1	2	2	Record Indicator	Literal "03"	Mandatory	
2	3	42	40	Claim Number	Customer Claim Number	Mandatory*	*Mandatory for Non-MSP Services
3	43	45	3	Claimant Number	Claimant Number	Optional	Required for Auto*
4	46	51	6	Filler	Filler	Blank	
5	52	60	9	Tax ID	Employer Tax ID	Mandatory*	*Mandatory for Non-MSP Services
6	61	110	50	Name	Employer Name	Mandatory*	*Mandatory for Non-MSP Services
7	111	160	50	Address Line 1	Employer Address Line 1	Optional	Mandatory for some state reporting**
8	161	210	50	Address Line 2	Employer Address Line 2	Optional	
9	211	240	30	City	Employer City	Optional	
10	241	242	2	State	Employer State	Optional	
11	243	251	9	Zip	Employer Zip	Optional	
12	252	252	1	Self Insured	Employer Self-Insured flag	Optional	
13	253	262	10	DOH	Employee's date of hire	Optional	
14	263	300	38	Filler	Filler	Blank	
				<b>Attorney Segment (Recommended for Auto)</b>			
<b>Field #</b>	<b>Position</b>	<b>Length</b>	<b>Description</b>	<b>Comment</b>	<b>Requirements</b>	<b>Requirements Description</b>	
1	1	2	2	Record Indicator	Literal "04"	Mandatory	
2	3	42	40	Claim Number	Customer Claim Number	Mandatory*	*Mandatory for Non-MSP Services
3	43	45	3	Claimant Number	Claimant Number	Optional	Required for Auto*
4	46	51	6	Filler	Filler	Blank	
5	52	101	50	Firm Name	Firm Name	Optional	<i>MSP Reporting item #61 in '80' record</i>
6	102	121	20	Last Name	Attorney last name	Optional	<i>MSP Reporting item #59 in '80' record</i>
7	122	141	20	First Name	Attorney first name	Optional	<i>MSP Reporting item #60 in '80' record</i>
8	142	191	50	Address	Attorney address	Optional	<i>MSP Reporting item #63 in '80' record</i>
9	192	221	30	City	Attorney city	Optional	<i>MSP Reporting item #65 in '80' record</i>
10	222	223	2	State	Attorney state	Optional	<i>MSP Reporting item #66 in '80' record</i>
11	224	232	9	Zip	Attorney zip	Optional	<i>MSP Reporting item #67-68 in '80' record</i>
12	233	242	10	Phone	Attorney phone	Optional	<i>MSP Reporting item #69 in '80' record</i>
13	243	300	58	Filler	Filler	Blank	
				<b>Policy Segment (Recommended for Auto)</b>			
<b>Field #</b>	<b>Position</b>	<b>Length</b>	<b>Description</b>	<b>Comment</b>	<b>Requirements</b>	<b>Requirements Description</b>	
1	1	2	2	Record Indicator	Literal "05"	Mandatory	
2	3	42	40	Claim Number	Customer Claim Number	Mandatory*	<i>*Mandatory for Non-MSP Services, MSP Reporting item #50 in '80' record</i>
3	43	45	3	Claimant Number	Claimant Number	Optional	Required for Auto*
4	46	51	6	Filler	Filler	Blank	
5	52	81	30	Policy Number	Policy Number	Mandatory*	<i>*Mandatory for Non-MSP Services, MSP Reporting item #49 in '80' record</i>
6	82	89	8	Policy Start Date	MMDDCCYY (Ex: "12312006")	Optional	

7	90	97	8	Policy End Date	MMDDCCYY (Ex: "12312006")	Optional	
8	98	99	2	Coverage State	2 character state code	Mandatory*	*Mandatory for Non-MSP Services
9	100	100	1	Coverage Type	M, P, C (MedPay, PIP, Commercial)	Mandatory*	*Mandatory for Non-MSP Services
10	101	111	11	Coverage Limit	9.2 policy coverage limit amount	Mandatory*	*Mandatory for Non-MSP Services
11	112	122	11	Deductible	9.2 policy deductible limit amount	Optional	
12	123	133	11	Co-Pay Maximum	9.2 policy co-pay limit amount	Optional	
13	134	136	3	Co-Pay Percent	Whole number policy co-pay percent	Optional	
14	137	140	4	Statute of Limitations	Expressed in number of months	Optional	
15	141	141	1	Coverage Indicator	Y or N	Mandatory*	*Mandatory for Non-MSP Services
16	142	142	1	Claim Status	Y or N if claim is still open	Optional	
17	143	153	11	Payments	9.2 insurer payments made against coverage	Mandatory*	*Mandatory for Non-MSP Services
18	154	164	11	Deductible Taken	9.2 insured deductible paid	Optional	Mandatory if Deductible exists
19	165	175	11	Co-Pay Taken	9.2 insured co-pay paid	Optional	Mandatory if Co-Pay exists
20	176	186	11	Reserve	9.2 reserve amount remaining	Optional	
21	187	261	75	Underwriter Name	Underwriter Name	Options	
22	262	300	39	Filler	Filler	Blank	
					<b>Customer Specific Defined Fields (Optional)</b>		
<b>Field #</b>	<b>Position</b>	<b>Length</b>		<b>Description</b>	<b>Comment</b>	<b>Requirements</b>	<b>Requirements Description</b>
1	1	2	2	Record Indicator	Literal "06"	Mandatory*	*Mandatory for Non-MSP Services
2	3	42	40	Claim Number	Customer Claim Number	Mandatory*	*Mandatory for Non-MSP Services
3	43	45	3	Claimant Number	Claimant Number	Optional	Required for Auto*
4	46	51	6	Filler	Filler	Blank	
5	52	86	35	ClaimGeneral1	Customer Defined Field - Can Be Used for Reporting	Optional	
6	87	121	35	ClaimGeneral2	Customer Defined Field - Can Be Used for Reporting	Optional	
7	122	156	35	ClaimGeneral3	Customer Defined Field - Can Be Used for Reporting	Optional	
8	157	191	35	ClaimGeneral4	Customer Defined Field - Can Be Used for Reporting	Optional	
9	192	221	30	ClaimGeneral5	Customer Defined Field	Optional	
10	222	251	30	ClaimGeneral6	Customer Defined Field	Optional	
11	252	281	30	ClaimGeneral7	Customer Defined Field	Optional	
12	282	300	19	Filler	Filler	Blank	
					<b>Customer Specific Defined Fields Continued (Optional)</b>		
<b>Field #</b>	<b>Position</b>	<b>Length</b>		<b>Description</b>	<b>Comment</b>	<b>Requirements</b>	<b>Requirements Description</b>
1	1	2	2	Record Indicator	Literal "07"	Mandatory*	*Mandatory for Non-MSP Services
2	3	42	40	Claim Number	Customer Claim Number	Mandatory*	*Mandatory for Non-MSP Services
3	43	45	3	Claimant Number	Claimant Number	Optional	Required for Auto*
4	46	51	6	Filler	Filler	Blank	
5	52	81	30	ClaimGeneral8	Customer Defined Field	Optional	
6	82	111	30	ClaimGeneral9	Customer Defined Field	Optional	
7	112	141	30	ClaimGeneral10	Customer Defined Field	Optional	
8	142	171	30	ClaimGeneral11	Customer Defined Field	Optional	
9	172	201	30	ClaimGeneral12	Customer Defined Field	Optional	
10	202	300	99	Filler	Filler	Blank	



				MSP Claim Segment (Mandatory for MSP)			
Field #	Position	Length	Description	Comment	Requirements	Requirements Description	
1	1	2	2	Record Indicator	Literal "80"	Mandatory	
2	3	29	27	Claim Number	The unique claim identifier by which the primary plan identifies the claim. If liability self-insurance or workers' compensation self-insurance, fill with 0's if you do not have or maintain a claim number	Mandatory	
3	30	32	3	Claimant Number	Claimant Number	Optional	Required for Auto*
4	33	62	30	Claim Record ID	Unique value needed as a key in the event that Claim Number changes.	Mandatory	
5	63	63	1	Query Flag	Field intended to tag a claim for the query process; 1 = include a claim in the query process; 0 = remove a claim from the query process	Optional	
6	64	75	12	Injured Party HICN		Conditional	Required if I.P. SSN not provided.
7	76	84	9	Injured Party SSN		Conditional	Required if I.P. HICN not provided.
8	85	124	40	Injured Party Last Name		Mandatory	
9	125	154	30	Injured Party First Name		Mandatory	
10	155	155	1	Injured Party Middle Name		Optional	
11	156	156	1	Injured Party Gender	0 = Unknown, 1 = Male, 2 = Female	Mandatory	
12	157	164	8	Injured Party Date of Birth	(MMDDCCYY)	Mandatory	
13	165	172	8	CMS Date of Incident (DOI)	As defined by CMS (MMDDCCYY)	Optional	<i>Required by CMS for Reportable Claim</i>
14	173	180	8	Industry Date of Incident (DOI)	DOI routinely used by the insurance/workers' compensation industry (MMDDCCYY)	Optional	
15	181	185	5	Alleged Cause of Injury, Incident, or Illness	ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) External Cause of Injury Code "E Code" describing the alleged cause of injury/illness (E800-E999).	Optional	Required for New Claim Records Submitted on or after January 1, 2011.
16	186	187	2	State of Venue	US postal abbreviation corresponding to the US State whose state law controls resolution of the claim.	Mandatory	
17	188	192	5	ICD-9 Diagnosis Code 1	ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) Diagnosis Code describing the alleged injury/illness.	Conditional	Required for New Claim Records Submitted on or after January 1, 2011.
18	193	197	5	ICD-9 Diagnosis Code 2	See explanation for Field 16. May include additional ICD-9 Diagnosis Code or ICD-9 External Cause of Injury Codes "E Code" (E800-E999) if applicable.	Conditional	Required when multiple body parts are affected. Provide if available/applicable.
19	198	202	5	ICD-9 Diagnosis Code 3	See explanation for Field 16 and 17.	Conditional	Required when 3 or more body parts are affected. Provide if available/applicable.
20	203	207	5	ICD-9 Diagnosis Code 4	See explanation for Field 16 and 17.	Conditional	Required when 4 or more body parts are affected. Provide if available/applicable.

21	208	212	5	ICD-9 Diagnosis Code 5	See explanation for Field 16 and 17.	Conditional	Required when 5 or more body parts are affected. Provide if available/applicable.
22	213	217	5	ICD-9 Diagnosis Code 6	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
23	218	222	5	ICD-9 Diagnosis Code 7	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
24	223	227	5	ICD-9 Diagnosis Code 8	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
25	228	232	5	ICD-9 Diagnosis Code 9	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
26	233	237	5	ICD-9 Diagnosis Code 10	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
27	238	242	5	ICD-9 Diagnosis Code 11	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
28	243	247	5	ICD-9 Diagnosis Code 12	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
29	248	252	5	ICD-9 Diagnosis Code 13	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
30	253	257	5	ICD-9 Diagnosis Code 14	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
31	258	262	5	ICD-9 Diagnosis Code 15	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
32	263	267	5	ICD-9 Diagnosis Code 16	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
33	268	272	5	ICD-9 Diagnosis Code 17	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
34	273	277	5	ICD-9 Diagnosis Code 18	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
35	278	282	5	ICD-9 Diagnosis Code 19	See explanation for Field 16 and 17.	Conditional	Provide if available/applicable.
36	283	332	50	Description of Illness/Injury	Free-form text description of illness or injury. Include description of major body part injured (e.g. head, arm, leg, etc.) and cause of illness/injury.	Conditional	Required through December 31, 2010, if no Alleged Cause of Illness/Injury Code (Field 14) or no ICD-9 Diagnosis Code 1 (Field 16) provided. Prior to January 1, 2011, RREs must provide either: 1) both the Alleged Cause of Injury, Incident, or Illness (Field 14) and at least one diagnosis code in the ICD-9 Diagnosis Code 1 (Field 16); or 2) the Description of Illness/Injury (Field 35). New claim records submitted on or after January 1, 2011 must contain both the Alleged Cause of Injury, Incident, or Illness (Field 14) and the ICD-9 Diagnosis Code 1 (Field 16).
37	333	333	1	Product Liability Indicator	Valid values: 1 = No 2 = Yes, but not a mass tort situation. 3 = Yes, and is a mass tort situation.	Optional	Required by CMS for Reportable Claim, Indicates whether injury, illness or incident was allegedly caused by/contributed to by a particular product.

38	334	373	40	Product Generic Name	Generic name of product alleged to be cause of injury, illness or incident. If no generic name applicable, supply brand name.	Conditional	Required if Product Liability Indicator (Field 36) is 3 (mass tort).
39	374	413	40	Product Brand Name	Brand name of product alleged to be cause of injury, illness or incident.	Conditional	Required if Product Liability Indicator (Field 36) is 3. Required for new claim records submitted on or after January 1, 2011, if Product Liability Indicator (Field 36) is either 2 or 3.
40	414	453	40	Product Manufacturer	Maker of product named in Fields 37 and/or 38 above.	Conditional	Required if Product Liability Indicator (Field 36) is 3. Required for new claim records submitted on or after January 1, 2011, if Product Liability Indicator (Field 36) is either 2 or 3.
41	454	653	200	Product Alleged Harm	Free-form description of harm allegedly caused by product named in Fields 37 and/or 38 above.	Conditional	Required if Product Liability Indicator (Field 36) is 3. Required for new claim records submitted on or after January 1, 2011, if Product Liability Indicator (Field 36) is either 2 or 3.
42	654	654	1	Self Insured Indicator	Valid values: Y = Yes, N = No - Indication of whether the reportable event involves self-insurance as defined by CMS.	Conditional	Required if Plan Insurance Type (Field 47) is E or L (Workers' Compensation or Liability).
43	655	655	1	Self-Insured Type	Valid values: I = Individual, O = Other than Individual Identifies whether the self-insured is an organization or individual.	Conditional	Required if Self Insured Indicator (Field 41) is Y.
44	656	695	40	Policyholder Last Name		Conditional	Required if Self-Insured Type (Field 42) = I.
45	696	725	30	Policyholder First Name		Conditional	Required if Self-Insured Type (Field 42) = I.
46	726	795	70	DBA Name	"Doing Business As" Name of self-insured organization	Conditional	Required if Self-Insured Type (Field 42) = O and Legal Name (Field 46) not provided.
47	796	865	70	Legal Name	Legal Name of self-insured organization/business.	Conditional	Required if Self-Insured Type (Field 42) = O and Legal Name (Field 46) not provided.
48	866	866	1	Plan Insurance Type	Type of insurance coverage or line of business provided by the plan policy or self-insurance. Valid values: D = No-Fault E = Workers' Compensation L = Liability	Optional	Required by CMS for Reportable Claim

49	867	875	9	TIN	Federal Tax Identification Number of the "applicable plan," whether liability insurance (including self-insurance), no-fault insurance or a workers' compensation law or plan.	Optional	Required by CMS for Reportable Claim
50	876	884	9	Office Code/Site ID	RRE-defined code to uniquely identify variations in insurer addresses/claim offices/Plan Contact Addresses. Defined by RRE. Used to uniquely specify different addresses associated with one TIN.	Optional	If only one address will be used per reported TIN, leave blank. Must have a corresponding entry with associated TIN on the TIN Reference File. A record must be submitted on the TIN Reference File for each unique TIN/Office Code combination.
51	885	914	30	Policy Number	The unique identifier for the policy under which the underlying claim was filed. RRE defined. If liability self-insurance or workers' compensation self-insurance, fill with 0's if you do not have or maintain a specific number reference.	Optional	<i>Required by CMS for Reportable Claim</i>
52	915	984	70	Plan Contact Department Name	Name of department for the Plan Contact to which claim-related communication and correspondence should be sent.	Optional	
53	985	1024	40	Plan Contact Last Name		Optional	
54	1025	1054	30	Plan Contact First Name		Optional	
55	1055	1064	10	Plan Contact Phone		Optional	
56	1065	1069	5	Plan Contact Phone Extension		Optional	
57	1070	1080	11	No-Fault Insurance Limit	Dollar amount of limit on no-fault insurance.	Conditional	Required if Plan Insurance Type (Field 71) is D (No-Fault). Implied decimal. No formatting (no \$ or , or .) Fill with all 9's if there is no dollar limit. Fill with all 0's if Plan Insurance Type (Field 71) is E (Workers' Compensation) or L (Liability Insurance (including Self-Insurance)).
58	1081	1088	8	Exhaust Date for Dollar Limit for No-Fault Insurance	Date on which limit was reached or benefits exhausted for No-Fault Insurance Limit (Field 81). (MMDDCCYY)	Conditional	Required if Plan Insurance Type (Field 71) is D (No-Fault) and benefit limit reached/exhausted. Fill with zeros if No-Fault limit has not been reached/exhausted or Plan Insurance Type (Field 71) is E (Workers' Compensation) or L (Liability Insurance (including Self-Insurance)).

59	1089	1089	1	Injured Party Representative Indicator	Code indicating the type of Attorney/Other Representative information provided. Valid values: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Space = None	Conditional	Required if Injured Party has a representative.
60	1090	1129	40	Representative Last Name		Conditional	Required if Injured Party has a representative.
61	1130	1159	30	Representative First Name		Conditional	Required if Injured Party has a representative.
62	1160	1229	70	Representative Firm Name		Optional	<i>Required on reports submitted on or after January 1, 2011, if Representative is associated with or a member of a firm.</i>
63	1230	1238	9	Representative TIN		Conditional	<i>Required if Injured Party has a representative. Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).</i>
64	1239	1288	50	Representative Mailing Address Line 1		Conditional	Required if Injured Party has a representative.
65	1289	1338	50	Representative Mailing Address Line 2		Optional	
66	1339	1368	30	Representative City		Conditional	Required if Injured Party has a representative.
67	1369	1370	2	Representative State		Conditional	Required if Injured Party has a representative.
68	1371	1375	5	Representative Mail Zip Code		Conditional	Required if Injured Party has a representative.
69	1376	1379	4	Representative Mail Zip+4		Optional	
70	1380	1389	10	Representative Phone		Conditional	Required if Injured Party has a representative.
71	1390	1394	5	Representative Phone Extension			
72	1395	1395	1	ORM Indicator	Indication of whether there is on-going responsibility for medicals (ORM). Fill with Y if there is ongoing responsibility for medicals. Valid values: Y - Yes N - No	Optional	Required by CMS for Reportable Claim. The Y value remains in this field even when an ORM Termination Date (Field 99) is submitted in this same record or a subsequent record.
73	1396	1403	8	ORM Termination Date	Date on-going responsibility for medicals ended, where applicable. (MMDDCCYY)	Conditional	See CMS IG for details.

74	1404	1411	8	TPOC Date	Initial date of Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medical services. (MMDDCCYY)	Conditional	See CMS IG for details.
75	1412	1422	11	TPOC Amount	Total Payment Obligation to the Claimant (TPOC) amount: Dollar amount of the total payment obligation to the claimant.	Optional	Required by CMS for Reportable Claim. See CMS IG for details.
76	1423	1430	8	Funding Delayed Beyond TPOC Start Date	If funding for the Total Payment Obligation to Claimant is delayed, provide actual or estimated date of funding. (MMDDCCYY)	Conditional	See CMS IG for details.
77	1431	1431	1	Claimant 1 Relationship	Relationship of the claimant to the injured party/Medicare beneficiary. E = Estate, Individual Name Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe") Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Space = Not applicable (rest of the section will be ignored)	Conditional	Required April 1, 2010 and subsequent if claimant is not the injured party.
78	1432	1440	9	Claimant 1 TIN	Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant 1.	Conditional	Required April 1, 2010 and subsequent if claimant is not the injured party.
79	1441	1480	40	Claimant 1 Last Name		Conditional	Required April 1, 2010 and subsequent if claimant is not the injured party.
80	1481	1510	30	Claimant 1 First Name		Conditional	Required April 1, 2010 and subsequent if claimant is not the injured party.
81	1511	1511	1	Claimant 1 Middle Initial		Optional	
82	1512	1582	71	Claimant 1 Entity/Organization Name	Name of Claimant 1 Entity/Organization.	Conditional	Required April 1, 2010 and subsequent if claimant is not the injured party and Claimant 1 Relationship is 'X', 'Y' or 'Z'.
83	1583	1632	50	Claimant 1 Mailing Address Line 1		Conditional	Required April 1, 2010 and subsequent if claimant is not the injured party.
84	1633	1682	50	Claimant 1 Mailing Address Line		Optional	
85	1683	1712	30	Claimant City		Conditional	Required April 1, 2010 and subsequent if claimant is not the injured party.
86	1713	1714	2	Claimant 1 State		Conditional	Required April 1, 2010 and subsequent if claimant is not the injured party.
87	1715	1719	5	Claimant 1 Zip		Conditional	Required April 1, 2010 and subsequent if claimant is not the injured party.

88	1720	1723	4	Claimant 1 Zip+4		Optional	
89	1724	1733	10	Claimant 1 Phone		Conditional	Required April 1, 2010 and subsequent if claimant is not the injured party.
90	1734	1738	5	Claimant 1 Phone Extension		Optional	
91	1739	1739	1	Claimant 1 (C1) Representative Indicator	Code indicating the type of Attorney/Other Representative information provided for Claimant 1. Valid values: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Space = Not applicable (rest of the section will be ignored)	Conditional	Required if Claimant 1 has a representative.
92	1740	1779	40	C1 Representative Last Name		Conditional	Required if Claimant 1 has a representative.
93	1780	1809	30	C1 Representative First Name		Conditional	Required if Claimant 1 has a representative.
94	1810	1879	70	C1 Representative Firm Name		Conditional	Required on reports submitted on or after January 1, 2011, if Representative is associated with or a member of a firm.
95	1880	1888	9	C1 Representative TIN	C1 representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).	Optional	Required by CMS for Reportable Claim if Claimant 1 has a representative.
96	1889	1938	50	C1 Representative Mail Address 1		Conditional	Required if Claimant 1 has a representative.
97	1939	1988	50	C1 Representative Mailing Address 2		Optional	
98	1989	2018	30	C1 Representative Mailing City		Conditional	Required if Claimant 1 has a representative.
99	2019	2020	2	C1 Representative State		Conditional	Required if Claimant 1 has a representative.
100	2021	2025	5	C1 Representative Zip		Conditional	Required if Claimant 1 has a representative.
101	2026	2029	4	C1 Representative Zip+4		Optional	
102	2030	2039	10	C1 Representative Phone		Conditional	Required if Claimant 1 has a representative.
103	2040	2044	5	C1 Representative Phone Extension		Optional	
104	2045	2500	456	Filler			
<b>MSP Additional Claimant Segment (Optional for MSP)</b>							
<b>Field #</b>	<b>Position</b>	<b>Length</b>	<b>Description</b>	<b>Comment</b>	<b>Requirements</b>	<b>Requirements Description</b>	

1	1	2	2	Record Indicator	Literal "81"	Mandatory	
2	3	29	27	Claim Number	The unique claim identifier by which the primary plan identifies the claim. If liability self-insurance or workers' compensation self-insurance, fill with 0's if you do not have or maintain a claim number	Conditional	Required by CMS for Reportable Claim if claim has additional claimants to be reported.
3	30	32	3	Claimant Number	Claimant Number	Conditional	Required for Auto*
4	33	33	1	Claimant 2 Relationship	Relationship of the claimant to the injured party/Medicare beneficiary. Valid values: E = Estate, F = Family, O = Other, Space = Not applicable (rest of the section will be ignored)	Conditional	Required on reports April 1, 2010 and subsequent.
5	34	42	9	Claimant 2 TIN	Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) of Claimant2. Must not match injured party named above or other claimant(s) listed on the Auxiliary Record.	Conditional	Required by CMS for Reportable Claim if claim has additional claimants to be reported.
6	43	82	40	Claimant 2 Last Name		Optional	Required by CMS for Reportable Claim if claim has additional claimants to be reported.
7	83	112	30	Claimant 2 First Name		Optional	Required by CMS for Reportable Claim if claim has additional claimants to be reported.
8	113	113	1	Claimant 2 Middle Initial		Optional	
9	114	184	71	Claimant 2 Entity/Organization Name	Name of Claimant 2 Entity/Organization.	Conditional	Required if Claimant 2 Relationship is 'X', 'Y' or 'Z'.
10	185	234	50	Claimant 2 Mailing Address Line 1		Optional	Required by CMS for Reportable Claim if claim has additional claimants to be reported.
11	235	284	50	Claimant 2 Mailing Address Line		Optional	
12	285	314	30	Claimant 2 City		Optional	Required by CMS for Reportable Claim if claim has additional claimants to be reported.
13	315	316	2	Claimant 2 State		Optional	Required by CMS for Reportable Claim if claim has additional claimants to be reported.
14	317	321	5	Claimant 2 Zip		Optional	Required by CMS for Reportable Claim if claim has additional claimants to be reported.
15	322	325	4	Claimant 2 Zip+4		Optional	If not applicable or unknown, fill with zeroes (0000).
16	326	335	10	Claimant 2 Phone		Optional	Required by CMS for Reportable Claim if claim has additional claimants to be reported.

17	336	340	5	Claimant 2 Phone Extension		Optional	
18	341	341	1	Claimant 2 (C2) Representative Indicator	Code indicating the type of Attorney/Other Representative information provided for Claimant 2 (C2). Valid values: A = Attorney, G = Guardian/Conservator, P = Power of Attorney, O = Other, Space = Not applicable (rest of the section will	Conditional	Required if Claimant 2 has a representative.
19	342	381	40	C2 Representative Last Name		Conditional	Required if Claimant 2 has a representative.
20	382	411	30	C2 Representative First Name		Conditional	Required if Claimant 2 has a representative.
21	412	481	70	C2 Representative Firm Name		Conditional	Required on reports submitted on or after January 1, 2011, if Representative is associated with or a member of a firm.
22	482	490	9	C2 Representative TIN	Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN)	Conditional	Required by CMS for Reportable Claim if claim has additional claimants to be reported.
23	491	540	50	C2 Representative Mailing Address Line 1		Conditional	Required if Claimant 2 has a representative.
24	541	590	50	C2 Representative Mailing Address Line 2		Optional	
25	591	620	30	C2 Representative City		Conditional	Required if Claimant 2 has a representative.
26	621	622	2	C2 Representative State		Conditional	Required if Claimant 2 has a representative.
27	623	627	5	C2 Representative Zip		Conditional	Required if Claimant 2 has a representative.
28	628	631	4	C2 Representative Zip+4		Optional	
29	632	641	10	C2 Representative Phone		Conditional	Required if Claimant 2 has a representative.
30	642	646	5	C2 Representative Phone Extension		Optional	
31	647	647	1	Claimant 3 Relationship	Relationship of the claimant to the injured party/Medicare beneficiary. Valid values: E = Estate, F = Family, O = Other, Space = Not applicable (rest of the section will be ignored)	Conditional	Valid values: E = Estate F = Family O = Other Space = Not applicable (rest of the section will be ignored) Required on reports April 1, 2010 and subsequent.
32	648	656	9	Claimant 3 TIN		Optional	
33	657	696	40	Claimant 3 Last Name		Optional	
34	697	726	30	Claimant 3 First Name		Optional	
35	727	727	1	Claimant 3 Middle Initial		Optional	

36	728	798	71	Claimant 3 Entity/Organization Name	Name of Claimant 3 Entity/Organization.	Conditional	Required if Claimant 3 Relationship is 'X', 'Y' or 'Z'.
37	799	848	50	Claimant 3 Mailing Address Line		Optional	
38	849	898	50	Claimant 3 Mailing Address Line		Optional	
39	899	928	30	Claimant 3City		Optional	
40	929	930	2	Claimant 3 State		Optional	
41	931	935	5	Claimant 3 Zip		Optional	
42	936	939	4	Claimant 3 Zip+4		Optional	
43	940	949	10	Claimant 3 Phone		Optional	
44	950	954	5	Claimant 3 Phone Extension		Optional	
45	955	955	1	Claimant 3 (C3) Representative Indicator		Optional	Valid values: A = Attorney G = Guardian/ConservatorP = Power of Attorney O = Other Space = Not applicable (rest of the section will be ignored) Required if Claimant 2 has a
46	956	995	40	C3 Representative Last Name		Optional	
47	996	1025	30	C3 Representative First Name		Optional	
48	1026	1095	70	C3 Representative Firm Name		Optional	
49	1096	1104	9	C3 Representative TIN		Optional	
50	1105	1154	50	C3 Representative Mailing Address Line 1		Optional	
51	1155	1204	50	C3 Representative Mailing Address Line 2		Optional	
52	1205	1234	30	C3 RepresentativeCity		Optional	
53	1235	1236	2	C3 Representative State		Optional	
54	1237	1241	5	C3 Representative Zip		Optional	
55	1242	1245	4	C3 Representative Zip+4		Optional	
56	1246	1255	10	C3 Representative Phone		Optional	
57	1256	1260	5	C3 Representative Phone Extension		Optional	
58	1261	1261	1	Claimant 4 Relationship		Optional	
59	1262	1270	9	Claimant 4 TIN		Optional	
60	1271	1310	40	Claimant 4 Last Name		Optional	
61	1311	1340	30	Claimant 4 First Name		Optional	
62	1341	1341	1	Claimant 4 Middle Initial		Optional	
63	1342	1412	71	Claimant 4 Entity/Organization Name	Name of Claimant 4 Entity/Organization.	Conditional	Required if Claimant 4 Relationship is 'X', 'Y' or 'Z'.
64	1413	1462	50	Claimant 4 Mailing Address Line		Optional	
65	1463	1512	50	Claimant 4 Mailing Address Line		Optional	
66	1513	1542	30	Claimant 4City		Optional	
67	1543	1544	2	Claimant 4 State		Optional	
68	1545	1549	5	Claimant 4 Zip		Optional	

69	1550	1553	4	Claimant 4 Zip+4		Optional	
70	1554	1563	10	Claimant 4 Phone		Optional	
71	1564	1568	5	Claimant 4 Phone Extension		Optional	
72	1569	1569	1	Claimant 4 (C4) Representative Indicator		Optional	Guardian/ConservatorP = Power of Attorney O = Other Space = Not applicable (rest of the section will be ignored) Required if Claimant 2 has a representative.
73	1570	1609	40	C4 Representative Last Name		Optional	
74	1610	1639	30	C4 Representative First Name		Optional	
75	1640	1709	70	C4 Representative Firm Name		Optional	
76	1710	1718	9	C4 Representative TIN		Optional	
77	1719	1768	50	C4 Representative Mailing Address Line 1		Optional	
78	1769	1818	50	C4 Representative Mailing Address Line 2		Optional	
79	1819	1848	30	C4 Representative City		Optional	
80	1849	1850	2	C4 Representative State		Optional	
81	1851	1855	5	C4 Representative Zip		Optional	
82	1856	1859	4	C4 Representative Zip+4		Optional	
83	1860	1869	10	C4 Representative Phone		Optional	
84	1870	1874	5	C4 Representative Phone Extension		Optional	
82	1875	2500	626	Filler			
					<b>MSP TPOC Payment Segment (Optional for MSP)</b>		
<b>Field #</b>	<b>Position</b>	<b>Length</b>		<b>Description</b>	<b>Comment</b>	<b>Requirements</b>	<b>Requirements Description</b>
1	1	2	2	Record Indicator	Literal "82"	Mandatory	
2	3	29	27	Claim Number	The unique claim identifier by which the primary plan identifies the claim. If liability self-insurance or workers' compensation self-insurance, fill with 0's if you do not have or maintain a claim number	Optional	Required by CMS for Reportable Claim if additional TPOC amounts are being reported
3	30	32	3	Claimant Number	Claimant Number	Optional	Required for Auto*
4	33	40	8	TPOC Date 2	(MMDDCCYY)	Optional	Required by CMS for Reportable Claim if additional TPOC amounts are being reported. Date of second (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM). Use this field only to report on an additional settlement, judgment, award or other payment.

5	41	51	11	TPOC Amount 2	2nd Total Payment Obligation to the Claimant (TPOC) amt: Dollar amt of the total payment obligation to the claimant for a settlement, judgment, award, or other payment in addition to/apart from the information which must be reported	Optional	Required by CMS for Reportable Claim if additional TPOC amounts are being reported. See Field 75 on the Claim Input Detail Record for format requirements. Use this field only to report on an additional settlement, judgment, award or other payment.
6	52	59	8	Funding Delayed Beyond TPOC Start Date 2	(MMDDCCYY)	Optional	Required by CMS for Reportable Claim if additional TPOC amounts are being reported. If funding for the Total Payment Obligation to Claimant 2 is delayed, provide actual or estimated date of funding.
7	60	67	8	TPOC Date 3	(MMDDCCYY)	Optional	Date of 3rd (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM). Use this field only to report on an additional settlement, judgment, award or other payment.
8	68	78	11	TPOC Amount 3	3rd Total Payment Obligation to the Claimant (TPOC) amt: Dollar amt of the total payment obligation to the claimant for a settlement, judgment, award, or other payment in addition to/apart from the information which must be reported	Optional	See Field 75 on the Claim Input Detail Record for format requirements. Use this field only to report on an additional settlement, judgment, award or other payment.
9	79	86	8	Funding Delayed Beyond TPOC Start Date 3	(MMDDCCYY)	Optional	If funding for the Total Payment Obligation to Claimant 3 is delayed, provide actual or estimated date of funding.
10	87	94	8	TPOC Date 4	(MMDDCCYY)	Optional	Date of 4th (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM). Use this field only to report on an additional settlement, judgment, award or other payment.
11	95	105	11	TPOC Amount 4	4th Total Payment Obligation to the Claimant (TPOC) amt: Dollar amt of the total payment obligation to the claimant for a settlement, judgment, award, or other payment in addition to/apart from the information which must be reported	Optional	See Field 75 on the Claim Input Detail Record for format requirements. Use this field only to report on an additional settlement, judgment, award or other payment.

12	106	113	8	Funding Delayed Beyond TPOC Start Date 4	(MMDDCCYY)	Optional	If funding for the Total Payment Obligation to Claimant 4 is delayed, provide actual or estimated date of funding.
13	114	121	8	TPOC Date 5	(MMDDCCYY)	Optional	Date of 5th (additional) Total Payment Obligation to the Claimant (TPOC) without regard to ongoing responsibility for medicals (ORM). Use this field only to report on an additional settlement, judgment, award or other payment.
14	122	132	11	TPOC Amount 5	5th Total Payment Obligation to the Claimant (TPOC) amt: Dollar amt of the total payment obligation to the claimant for a settlement, judgment, award, or other payment in addition to/apart from the information which must be reported	Optional	See Field 75 on the Claim Input Detail Record for format requirements. Use this field only to report on an additional settlement, judgment, award or other payment.
15	133	140	8	Funding Delayed Beyond TPOC Start Date 5	(MMDDCCYY)	Optional	If funding for the Total Payment Obligation to Claimant 5 is delayed, provide actual or estimated date of funding.
16	141	200	60	Filler		Conditional	
<b>File Trailer Segment (Mandatory)</b>							
<b>Field #</b>	<b>Position</b>	<b>Length</b>	<b>Description</b>	<b>Comment</b>	<b>Requirements</b>	<b>Requirements Description</b>	
1	1	2	2	Record Indicator	Literal "99"	Mandatory	
2	3	42	40	Blank	Blanks	Mandatory	Blanks for Trailer Segment
3	43	51	9	Blank	Blank	Mandatory	Blanks for Trailer Segment
4	52	61	10	Claim Header (01) Count	Expected number of claim segments in file	Mandatory	
5	62	71	10	Patient Count (02) Count	Expected number of patient segments in file	Mandatory	
6	72	81	10	Employer (03) Count	Expected number of employer segments in file	Mandatory	
7	82	91	10	Attorney (04) Count	Expected number of attorney segments in file	Mandatory	
8	92	101	10	Policy Count (05)	Expected number of policy segments in file	Mandatory	
9	102	111	10	Customer Specific Fields (06) Count	Expected number of Customer Specific (06) segments in file	Mandatory	
10	112	121	10	Customer Specific Fields (07) Count	Expected number of Customer Specific (07) segments in file	Mandatory	
11	122	131	10	Claim Payment (08) Count	Expected number of Claim Payment segments in file	Mandatory	
12	132	141	10	Claim Header 2 (1A) Count	Expected number of claim 2 segments in file	Mandatory	
13	142	151	10	MSP Primary (80) Count	Expected number of MSP Primary segments in file	Mandatory	
14	152	161	10	MSP Addl Claimant (81) Count	Expected number of MSP Addl Claimant segments in file	Mandatory	
15	162	171	10	MSP TPOC Payment (82) Count	Expected number of MSP TPOC Pmt segments in file	Mandatory	
16	172	300	129	Filler	Filler		

*	Claimant Number is a mandatory field for all Auto Claims.						
	Claimant Number is a mandatory field for Auto and WC claims that are sent in the same file.						
	If a claimant number is sent it needs to be included on all segments.						
**	May be mandatory for some state reporting/EDIs						