Attachment 7

Minimum Data Set

NCPDP V3.C (Missouri Medicaid Specifications)

o The format of this document relates Missouri Medicaid requirements to the NCPDP Telecommunications Standard Format Version 3 Release C.

Field No.	Field Name	Table Value	Encounter Req.
101	BIN-MO MEDICAID	C-93	YES
102	VERSION NUMBER	C-94	YES
103	TRANSACTION CODE	C-95	YES
104	PROCESSOR NUMBER (HP'S 81 NUMBER)		
201	~~PROVIDER NUMBER~~ NABP NUMBER		
301	GROUP NUMBER		N/A
302	CARDHOLDER NUMBER	C-1	YES
303	PERSCN CODE		N/A
304	DATE OF BIRTH		N/A
305	SEX CODE		N/A
306	RELATIONSHIP CODE		N/A
308	OTHER COVERAGE CODE		YES
401	DATE FILLED	C-16	YES
FS	C7		NO
307	[illegible]	C-44	YES
FS	c9		NO
309	ELIGIBILITY CLARIFICATION CODE		N/A
FS	CA		NO
310	PATIENT FIRST NAME	c-2	YES
FS	CB		NO
311	PATIENT LAST NAME	C-2	YES
GS	1	C-12	NO
402	PRESCRIPTION NUMBER	C-4	YES
403	NEW/REFILL CODE	C-5	YES
404	METRIC QUANTITY	C-28	YES
405	DAYS SUPPLY	c-29	YES
406	COMPOUND CODE	C-69	YES
407	NDC NUMBER	C-26	YES

HCFA-1500/DENTAL OVERVIEW

HCFA-1500 claims have a minimum of 5 records per claim. One CA0 record, cne DA0 reccrd, one EA0 record, 1 - 12 FA0 records, and one XA0 record. Dental claims have a minimum of 6 records per claim, one CA0 record, one DA0 record, one EA0 record, 1 -13 FAG records, 1 - 13 F30 records and one XA0 record.

Required Records

AA0 Pile Header Record "Submitter Data"
BA0 Batch Header Record "Provider Data 1"
CA0 Claim Header Record "Patient Data"
DA0 Insurance Information "Payor Data 1"
EA0 Claim Record
FA0 Service Line Detail "Root Segment"
FB0 Service Line Detail "Medical Segment"
FD0 Service Line Detail "Dental Segment" (Dental Claims Cnly)
XA0 Claim Trailer Record "Record Summary"
YA0 Eatch Trailer Record
ZA0 File Trailer Record

Record Layout Charts (for HCFA-1500 and Dental)
Description of Headings

Field No. - Field Number
Field Name - Field Name
Table Value - Data element identifier for the Data De inition Table.
Encounter Req. - A "YES" implies that the field is required for all claims. A "NO" implies that the field is not always required or not required for all Medicaid claims or the field is optional. A "N/A" implies that the field is NOT applicable to Missouri Medicaid billing-

Missouri Division of Medical Services has determined that the Health Plans should submit only paid claims to GTE Data Services..

It is the responsibility of the Health Plan to resubmit all encounter claims that error off or reject as a result of MMIS processing.

Adjustments will not be accepted. The Health Plan must maintain GTEDS' Internal Control Number from the Remittance Advice Records in order tc submit the Encounter Void Layout.

RECORD NAME: **FILE HEADER** RECORD **RECORDTYPE: AA0**
"SUBMITTER DATA"

c **Required by Medicaid - Must be first record** for NSF
o Must **be** followed by BA0

FieldNo.	Field Name	Table Value	Encounter Req.
01	RECORD ID "AA0"	C-24	AA0
02	SUB ID		NO
03	RESERVED (AA0-03.0)		NO
04	SUBMISSION TYPE		NO
05	SUBMISSION NO		NO
06	SUB NAME	C-47	YES
07	SUB ADDR1	C-47	YES
08	SUB ADDR2	C-47	YES
09	SUB CITY	C-47	YES
10	SUB STATE	C-47	YES
11	SUB ZIP	C-47	YES
12	SUB REGION	C-47	NO
13	SUB CONTACT	C-47	NO
14	SUB PHONE	C-47	YES
15	CREATION DATE		NO
16	SUBMISSION TIME		NO
17	RECEIVER ID		NO
18	RECEIVER TYPE CODE		NO
19	VERSION CODE-NATIONAL		00104
20	VERSION CODE-LOCAL		NO
21	TEST/PROD IND		NO
22	PASSWORD		NO
23	RETRANSMISSION STATUS		NO
24	ORIGINAL SUB ID		NO
25	VENDOR APP CAT		NO
26	VENDOR SOFTWARE VER		NO
27	VENDOR SOFTWARE UPDTE		NO
28	FILLER-NATIONAL		YES

29	FILLER-LOCAL		YES

RECORD NAME: **BATCH HEADER RECORD** RECORDTYPE: **BA0**
"PROVIDER DATA 1"

C Required by **Medicaid**
C Must be followed by **EA1** or **CA0**
O **Must** follow either **AA0** or YA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "BA0"	C-24	BA0
02	EMC PROV ID		NO
03	BATCH TYPE	C-62	YES
04	BATCH NO		NO
05	BATCH ID		NO
06	PROV TAX ID		NO
07	RESERVED (BA0-07.0)		NO
08	PROV TAX ID TYPE		NO
09	PROV MEDICARE NO		NO
10	PROV UPIN-USIN ID		NO
11	RESERVED (BA0-11.0)		NO
12	PROV MEDICAID ID	C-8	YES
13	PROV CHAMPUS NO		NO
14	PROV BLUE SHIELD NO		NO
15	PROV COMMERCIAL NO		NO
16	PROV NO 1		NO
17	PROV NO 2		NO
18	ORGANIZATION NAME	C-33	YES
19	PROV LAST NAME		NO
20	PROV FIRST NAME		NO
21	PROV MI		NO
22	PROV SPECIALTY		NO
23	SPECIALTY LICENSE NO		NO
24	STATE LICENSE NO		NO
25	DENTIST LICENSE NO		NO
26	ANESTHESIA LICENSE NO		NO
27	FILLER-NATIONAL		YES
28	FILLER-LOCAL		YES

RECORD NAME: **BATCH HEADER RECORD "PROVIDER DATA 2"** **RECORD TYPE: BA1**

- Not Required by Medicaid
- Must follow BA0
- Must be followed by CA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "BA1"	C-24	BA1
02	EMC PROV ID		NO
03	BATCH TYPE		NO
04	BATCH NO		NO
05	BATCH ID		NO
06	PROV TYPE ORG		NO
07	PROV SVC ADDR1		NO
08	PROV SVC ADDR2		NO
09	PROV SVC CITY		NO
10	PROV SVC STATE		NO
11	PROV SVC ZIP		NO
12	PROV SVC PHONE		NO
13	PROV PAY TO ADDR1		NO
14	PROV PAY TO ADDR2		NO
15	PROV PAY TO CITY		NO
16	PROV PAY TO STATE		NO
17	PROV PAY TO ZIP		NO
18	PROV PAY TO PHONE		NO
19	FILLER-NATIONAL		YES
20	FILLER-LOCAL		YES

RECORD NAME: CLAIM HEADER RECORD "PATIENT DATA"

RECORD TYPE: CA0

O Required by Medicaid
o Must follow BA0 or BA1 or XA0
o Must be followed by CB0 or DA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "CA0"	c-24	CA0
02	RESERVED (CA0-02.0)		
03	PAT CONTROL NO	C-31	NO
04	PAT LAST NAME	c-2	YES
05	PAT FIRST NAME	c-2	YES
06	PAT MI		NO
07	PAT GENERATION		NO
08	PAT DATE OF BIRTH		NO
09	PAT SEX	c-49	NO
10	PAT TYPE OF RESIDENCE		NO
11	PAT ADDR1		NO
12	PAT ADDR2		NO
13	PAT CITY		NO
14	PAT STATE		NO
15	PAT ZIP		NO
16	PAT PHONE		NO
17	PAT MARITAL STATJS		NO
18	PAT STUDENT STATUS		NO
19	PAT EMPLOYMENT STATUS		NO
2c	PAT DEATH IND		NO
21	PAT DATE OF DEATH		NO
22	OTHER INSURANCE IND	C-63	YES
23	CLAIM EDITING IND		NO
24	TYPE OF CLAIM IND		NO
25	LEGAL REP IND		NO
26	ORIGIN CODE		NO
27	PAYOR CLM CONTROL NO		NO
28	PROVIDER NUMBER		NO

29	CLAIM ID NO		NO
30	FILLER-NATIONAL		YES
31	FILLER-LOCAL		YES

RECORD NAME: CLAIM HEADER RECORD "LEGAL REPRESENTATIVE DATA" RECORD TYPE: CB0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "CB0"	C-24	CB0
02	RESERVED (CEO-02.0)		NO
03	?AT CCNTROL NO		NO
04	RESP PERSON LAST NAME		NO
05	RESP PERSON FIRST NAME		NO
06	RESP PERSON MI		NO
07	RESP PERSON ADDR1		NO
08	ESP PERSON ADDR2		SO
09	RESP PERSON CITY		NO
10	RESP PERSON STATE		NO
11	RESP PERSON ZIP		NO
12	RESP PERSON PHONE		NO
13	FILLER-NATIONAL		YES
14	FILLER-LOCAL		YES

RECORD NAME: INSURANCE INFORMATION "PAYOR DATA 1" RECORD TYPE: DA0

c Required for Medicaid processing
o Must follow CA0 or CB0
o Must be followed by DA1, DA2 or EA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "DA0"	C-24	DA0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		NO
04	CLAIM FILING IND		NO
05	SOURCE OF PAY	C-27	NO
06	INSURANCE TYPE CODE		NO
07	PAYOR ORGANIZATION ID		NO
08	PAYOR CLAIM OFFICE NO		NO
09	PAYOR NAME	C-53	YES
10	GROUP NO		NO
11	GROUP NAME		NO
12	PPO/HMO IND		NO
13	PPO IC		NO
14	PRIOR AUTH NO		NO
15	ASSIGN OF BENEFITS		NO
16	PAT SIGNATURE SOURCE		NC
17	PAT REL TO INSURED		NO
18	INSURED IB NO	C-I	YES
19	INSURED LAST NAME		NC
20	INSURED FIRST NAME		NO
21	INSURED MI		NO
22	INSURED GENERATION		NO
23	INSURED SEX		NO
24	INSURED DATE OF BIRTH		NO
25	INSURED EMPL STATUS		NO
26	SUPPLEMENTAL INS IND		NO
27	INSURANCE LOCATION ID		NO
28	FILLER-NATIONAL		YES

2s	FILLER-LOCAL	

RECORD NAME: INSURANCE INFORMATION 'PAYOR DATA 2" RECORD TYPE: DA1

o Not Required by Medicaid
3 Must follow DA0
o Must be followed by DA2 or EA0

Field No.	Field Name	Table Value	Encounter Req.
01	REMRD ID "DA1"	c-24	DA1
02	SEQUENCE NO	c-21	YES
03	PAT CONTROL NO		NO
04	PAYOR ADDR1		NO
05	PAYOR ADDR2		NC
06	PAYOR CITY		NC
09	DISALLOWED COST CONT		NO
10	DISALLOWED OTHER		NO
11	ALLOWED AMOUNT		NO
12	DEDUCTIBLE AMOUNT		NO
13	COINSURANCE AMOUNT		NO
14	PAYOR AMOUNT PAID		NO
15	ZERO PAY IND		NO
16	ADJUDICATION IND 1		NO
17	ADJUDICATION IND 2		NO
18	ADJUDICATION IND 3		NO
19	CHAMPUS SPNSR BRANCH		NO
20	CHAMPUS SPNSR GRADE		NO
21	CHAMPUS SPNSR STATUS		NO
22	INS CARD EFFECT DATE		NO
23	INS CARD TERM DATE		NO
24	BALANCE DUE		NO
25	FILLER-NATIONAL		YES
26	FILLER-LOCAL		YES

RECORD NAME: INSURANCE INFORMATION "PAYOR DATA 3" RECORD TYPE: DA2

- Not Required by Medicaid
- Must follow DA0 or DA1
- Must be followed by EA0

Field No.	Field Name	Table Value	Encounter-Req.
01	RECORD ID "DA2"	c-24	3A2
02	SEQUENCE NO	c-21	YES
03	PAT CONTROL NO		NO
04	INSURED ADDR1		NO
05	INSURED ADDR2		NO
06	INSURED CITY		NO
07	INSURED STATE		NO
08	INSURED ZIP		NO
09	INSURED PHONE		NO
10	INSURED RETIRE DATE		NO
11	INSURED SPOUSE RETIRE		NO
12	INSURED EMPLR NAME		NO
13	INSURED EMPLR ADDR1		NO
14	INSURED EMPLR ADDR2		NO
15	INSURED EMPLR CITY		NO
16	INSURED EMPLR STATE		NO
17	INSURED EMPLR ZIP		NO
18	EMPLOYEE ID NO		NO
19	FILLER-NATIONAL		YES
23	FILLER-LOCAL		YES

RECORD NAME: CLAIM RECORD RECORDTYPE: EA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "EA0"	c-24	EA0
02	RESERVED (EA0-02.0)		NO
03	PAT CONTROL NO		NO
04	EMPL RELATED IND		NO
05	ACCIDENT IND	C-16	NO
06	SYMPTOM IND	C-64	NO
37	ACCIDENT/SYMPTOM DATE	C-65	NO
08	EXT CAUSE OF ACCIDENT		NO
09	RESPONSIBILITY IND		NO
10	ACCIDENT STATE		NO
11	ACCIDENT HOUR		NO
12	ABUSE IND		NO
13	RELEASE OF INFO IND		NO
14	RELEASE OF INFO DATE		NO
15	SAME/SIMILAR SYMP IND		NO
16	SAME/SIMILAR SYMP DT		NO
17	DISABILITY TYPE		NO
18	DISABILITY-FROM DATE		NO
19	DZSABILI'IY-TO DATE		NO
20	REFER PROV ID NO	C-15	NO
21	RESERVED (EA0-21.0)		NO
22	RE-FER DROV LAST		NO
23	REFER PROV FIRST		NO
24	REFER PROV MI		NO
25	REFER PROV STATE		NO
25	ADMISSION GATE-1	C-16	NO
27	DI5CHARGE DATE-1	C-16	NO
28	LAB IND	C-44	NO

29	LAB CHARGES		NO
30	DIAGNOSIS CODE-1	C-17	YES
31	DIAGNOSIS CODE-2	C-17	NO
32	DIAGNOSIS CODE-3	C-17	NO
33	DIAGNOSIS CODE-4	C-17	NO
34	PROV ASSIGN IND		NO
35	PROV SIGNATURE IND		NO
36	PROV SIGNATURE DATE		NO
37	FACILITY/LAB NAME	C-66	NO
38	DOCUMENTATION IND		NO
39	TYPE OF DOCUMENTATION		NO
40	FUNCTIONAL STATUS CODE		NO
41	SPECIAL PROGRAM IND		NO
42	CHAMPUS NONAVAIL IND		NO
43	SUPV PROV IND		NO
44	RESUBMISSION CODE		NO
45	RESUB REFERENCE NO	C-41	NO
46	DATE LAST SEEN		NO
47	DATE DOCUMENT SENT		NO
48	FILLER-NATIONAL		YES
49	FILLER-LOCAL		YES

RECORD NAME: CLAIM RECORD RECORD TYPE: EA1

- Not Required by Medicaid
- Must follow EA0
- Must be followed by EA2 or FA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "EA1"	C-24	EA1
02	RESERVED (EA1-02.0)		NO
03	PAT CONTROL NO		NO
04	FACILITY/LAB ID NO		NO
05	RESERVED (EA1-05.0)		NO
C6	FACILITY/LAB ADDR1		NO
07	FACILITY/LAB ADDR2		NO
08	FACILITY/LAB CITY		NO
09	FACILITY/LAB STATE		NO
10	FACILITY/LAB ZIP CODE		NO
11	MEDICAL RECORD NO		NO
12	RETURN TO WORK DATE		NO
13	CONSULT/SURGERY DATE		NO
14	ADMISSION DATE-2		NO
15	DISCHARGE CATE-2		YO
16	SUPV PROV ID NO		NO
17	RESERVED (EA1-17.0)		NO
18	SUPV PROV LAST		NO
19	SUPV PROV FIRST		YO
20	SUPV PROV MI		NO
21	SUPV PROV STATE		NO
22	EMT/PARAMEDIC LAST		NO
23	EMT/PARAMEDIC FIRST		YO
24	EMT/PARAMEDIC MI		NO
25	FILLER-NATIONAL		YE5
26	FILLER-LOCAL		YES

RECORD NAME: CLAIM RECORD RECORDTYPE: EA2
"EARLY PERIODIC SCREENING DIAGNOSTIC TESTING (EPSDT)"

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "EA2"	C-24	EA2
02	RESERVED (EA2-02.0)		NO
03	PAT CONTROL NO		NC
04	SCREENING TYPE		NO
05	MED HIST OBTAIN PERF		NC
06	MED HIST OBTAIN FIND		NC
07	PHYSICAL EXAM PERF		NC
08	PHYSICAL EXAM FIND		NC
09	VISION ASSESS PERF		NC
10	VISION ASSESS FIND		NC
11	HEARING ASSESS PERF		NC
12	HEARING ASSESS FIND		NO
13	DENTAL ASSESS PERF		NO
14	DENTAL ASSESS FIND		NC
15	DEVELOP ASSESS PERF		NC
16	DEVELOP ASSESS FIND		NO
17	NUT ASSESS PERF		NC
18	NUT ASSESS FIND		NO
20	CARD ASSESS PERF		NC
20	CARD ASSESS FIND		NO
21	GEN/UR ASSESS PERF		NO
22	GEN/UR ASSESS FIND		NO
23	DIABETES ASSESS PERF		NO
24	DIABETES ASSESS FIND		NO
25	OTH. SYS. ASSESS PERF		NO
26	OTH. SYS. ASSESS FIND		NO
27	OTH. SYS. ASSESS DESC		NC

28	HBG/HCT LAB TEST PERF		NO
29	HBG/HCT LAB TEST FIND		NO
30	URINALY LAB TST PERF		NO
3:	URINALY LAB TST FIND		NO
32	SICKLE CELL LAB PERF		NO
33	SICKLE CELL LAB FIND		NO
34	BLOOD LEAD LAB PERF		NO
35	BLOOD LEAD LAB FIND		NO
36	TINE TEST PERF		NO
37	TINE TEST FIND		NO
36	OTHER TEST 1 PERF		NO
34	OTHER TEST 1 FIND		NO
40	OTHER TEST 1 DESC		NO
41	OTHER TEST 2 PERF		NO
42	OTHER TEST 2 FIND		NO
43	OTHER TEST 2 DESC		NO
44	TREATMENT ITEM NO 1		NO
45	TREATMENT ITEM NO 2		NO
46	TREATMENT ITEM NO 3		NO
47	TREATMENT ITEM NO 4		NO
48	TREATMENT ITEM NO 5		NO
49	TREATMENT ITEM NO 6		NO
50	TREATMENT ITEM NO 7		NO
51	TREATMENT ITEM NO 8		NO
52	TREATMENT ITEM NO 9		NO
53	TREATMENT ITEM NO 10		NO
54	TREATMENT ITEM NO 11		NO
55	TREATMENT ITEM NO 12		NO
56	TREATMENT ITEM NO 13		NO
57	TREATMENT ITEM NO 14		NO
58	TREATMENT ITEM NO 15		NO
59	TREATMENT ITEM NO 16		NO
63	TREATMENT STAT NO1 IN		KO
61	TREATMENT STAT NO2 IN		NO

62	TREATMENT STAT NO3 IN		NO
63	TREATMENT STAT NO4 IN		NO
64	TREATMENT STAT NO1 DE		NO
65	TREATMENT STAT NO2 DE		NO
66	TREATMENT STAT NO3 DE		NO
67	TREATMENT STAT NO4 DE		NO
68	TREATMENT STAT NO1 NR		NO
69	TREATMENT STAT NO2 NR		NO
70	TREATMENT STAT NO3 NR		NO
71	TREATMENT STAT NO4 NR		NO
72	REFERRAL ITEM NO 1		NO
73	REFERRAL ITEM NO 2		NO
74	REFERRAL ITEM NO 3		NO
75	REFERRAL ITEM NO 4		NO
76	REFERRAL ITEM NO 5		NO
77	REFERRAL ITEM NO 6		NO
78	REFERRAL ITEM NO 7		NO
79	REFERRAL ITEM NO 8		NO
80	IMMUN POLIO GIVEN		NO
81	IMMUN POLIO NOT		NO
82	IMMUN DPT/TD GIVEN		NO
83	IMMUN DPT/TD NOT		NO
84	IMMUN MEAS GIVEN		NO
85	IMMUN MEAS NOT		NO
86	IMMUN MUMPS GIVEN		NO
87	IMMUN MUMPS NOT		NO
88	IMMUN RUBELLA GIVEN		NO
89	IMMUN RUBELLA NOT		NO
90	IMMUN HIB GIVEN		NO
91	IMMUN HIB NOT		NO
92	IMMUN OTHER GIVEN		NO
93	IMMUN OTHER DESC		NO
94	FILLER-NATIONAL		YES
95	FILLER-LOCAL		YES

RECORD NAME: SERVICE LINE DETAIL "ROOT SEGMENT" RECORDTYPE: FAO

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "FAO"	C-24	FAO
02	SEQUENCE NO	c-21	YES
03	PAT CONTROL NO		NO
04	LINE ITEM CONTROL NO	C-67	NO
05	SVC FROM DATE	C-16	YES
06	SVC TO DATE	C-i6	YES
07	PLACE OF SVC	C-14	YES
08	TYPE GF SVC CODE	C-11	YES
09	ECPCS PROCEDURE CODE	C-30	YES
10	HCPCS MODIFIER 1	c-35	NO
11	HCPCS MODIFIER 2	c-35	NO
12	HCPCS MOCIFIER 3		NO
13	LINE CHARGES	c-10	YES
14	CIAG CODE POINTER1	C-68	YES
15	CIAG CODE POINTER2		NO
16	EIAG CODE POINTER3		NO
17	DIAG CODE POINTER4		NO
18	UNITS OF SVC	c-28	YES
19	ANESTHESIA/OXYGEN MIN		NO
2G	EMERGENCY IND		NO
21	COB IND		NO
22	HPSA IND		NO
23	RENDERING PRGV ID	t-19	YES
24	REFERRING PROV ID		NO
25	REFERRING PRGV STATE		NO
26	PUR SVC IND		NO
27	DISALLOWED COST CONT		NO
28	DISALLOWED OTHER		NO

29	REVIEW BY CODE IND		NO
30	MULTI PROCEDURE IND		NO
31	MAMMOGRAPHY CERT NG		NO
	CLASS FINDINGS		NO
33	PODIATRY SVC COND		NO
34	CLIA ID NO		NO
35	PRIMARY PAID AMOUNT		NO
36	HCPCS MODIFIER 4		NO
37	PROVIDER SPECIALTY		NO
38	PODIATRY THERAPY IND		NO
39	PODIATRY THERAPY TYPE		NO
40	HOSPICE EMPLOYES PROV IND		NC
41	HGB/HCT DATE		NO
42	HGB RESULT		NO
43	HCT RESULT		NO
44	PATIENT WEIGHT		NO
45	EPO DOSAGE		
46	SERUM CREATINE DATE		
47	CREATINE RESULT		
48	OBLIGATED ACCEPT AMT		NO
49	FILLER-NATIONAL		YES
50	FILLEX-LOCAL		YES

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "FB0"	C-24	FB0
02	SEQUENCE NO	c-21	YES
03	PAT CONTROL NO		NO
04	LINE ITEM CONTROL NO		NO
05	PUR SVC CHARGE		NO
06	ALLOWED AMOUNT		NO
c7	DEDUCTIBLE AMOUNT		NO
08	COINSURANCE AMOUNT		NO
09	ORDERING PROV ID		NO
10	ORDERING PROV STATE		NO
11	PUR SVC PROV IC		NO
12	PUR SVC STATE		NO
13	PEN GRAMS OF PROTEIN		NO
14	PEN CALORIES		NO
15	NATIONAL DRUG CODE		NO
16	NATIONAL DRUG UNITS		NO
17	PRESCRIPTION NO		NO
18	PRESCRIPTION DATE		NO
19	PRESCRIPT NO OF MOS		NO
20	SPEC PRICING IND		NO
21	COPAY STATUS IND		NO
22	EPSDT IND	c-44	NO
23	FAMILY PLANNING IND	c-44	NO
24	DME CHARGE IND		NO
25	EDSA FACILITY ID		NO
25	HPSA FACILITY ZIP		NO

28	PUR SVC ADDR1		NO
29	PUR SVC ADDR2		NO
30	PUR SVC CITY		NO
31	PUR SVC ZIP		NO
32	PUR SVC PHONE		NO
33	DRUG DAYS SUPPLY		NO
34	FILLER-NATIONAL		YES
35	FILLER-LOCAL		YES

RECORD NAME: SERVICE LINE DETAIL "MEDICAL SEGMENT"

RECORD TYPE: FB1

- Not Required by Medicaid
- Must follow FB0
- Must be followed by FB2 - XA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "FB1"	c-24	FB1
02	SEQUENCE NO	c-21	YES
03	PAT CONTROL NO		NO
04	LINE ITEM CONTROL NO		NO
05	PLACE OF SVC NAME		NO
06	ORDERING PROV LAST		NO
07	ORDERING PROV FIRST		NO
08	ORDERING PROV MI		NO
09	ORDERING PROV UPIN		NO
13	REFERRING PROV LAST		NO
11	REFERRING PROV FIRST		NO
12	REFERRING PROV MI		NO
13	REFERRING PROV UPIN		NO
14	RENDERING FROV LAST		NO
15	RENDERING PROV FIRST		NO
16	RENDERING PROV MI		NO
17	RENDERING PROV UPIN		NO
18	SUPV PROV LAST		NO
19	SUPV PROV FIRST		NO
20	SUPV PROV MI		NO
21	SUPV PROV ID		NO
22	SUPV PROV UPIN		NO
23	FILLEX-NATIONAL		YES
24	FILLER-LOCAL		YES

RECORD NAME: SERVICE LINE DETAIL "MEDICAL SEGMENT"

RECORD TYPE: FB2

- Not Required by Medicaid
- Must follow FB0 and FB1
- Must be follow by FD0 - XA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD I3 "FB2"	c-20	FB2
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		NO
04	LINE ITEM CONTROL NO		NO
05	PRO?" TYPE IND A		NO
06	PROV A ADDR 1		NO
07	PROV A ADDR 2		NO
08	PROV A CITY		NO
09	PROV A STATE		NO
10	PROV A ZIP		NO
	PROV TYPE IND 3		NO
	PROV B ADDR 1		NO
	PROV B ADDR 2		NO
	PROV B CITY		NO
15	PROV B STATE		NO
	PROV B ZIP		NO
17	PROV TYPE IND C		NO
18	PROV C ADDR 1		NO
	PROV C ADDR 2		NO
20	PROV C CITY		NC
21	PROV C STATE		NO
22	PROV C ZIP		NC
23	FILLER-NATIONAL		YES

RECORD NAME: SERVICE LINE DETAIL "DENTAL SEGMENT" RECORD TYPE: FDO

- Required for Medicaid processing-Dental claims only
- Must follow FBO - FB2
- Must be followed by FAO OR XAO

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "FDO"	C-24	FDC
02	SEQGENCE NO	c-21	YES
03	PAT CONTROL NO		NO
04	LINE ITEM CONTROL NO		NO
05	TOOTH CODE NUMBER 1	C-38	YES
06	TOOTH SURFACE(S) 1	c-39	NC
07	TOOTH CODE NUMBER 2		NO
08	TOOTH SURFACE(S) 2		NC
09	TOOTH CODE NUMBER 3		NO
10	TOOTH SURFACE(S) 3		NO
11	TOOTH CODE NUMBER 4		NO
12	TOOTH SURFACE(S) 4		NO
13	INITIAL PLACE IND	c-37	NO
14	PRIOR PLACE DATE		NO
15	IMPRESS/PRESCRIPT DT		NC
16	REPLACEMENT REASON		NO
17	ORTHO TREAT IND		NO
18	TREATMENT LENGTH		NO
19	DATE APPL INSERTED		NO
20	DATE APPL REMOVED		NO
21	RESERVED (FDO-21.0)		NO
22	DATE APPL REPLACED		NO
23	MOS TREAT REMAINING		NO
24	DT 1ST VISIT CUR SER		NO
25	RESERVED (FDO-25.0)		NC
26	PRE DETERMINATION ID		NC
27	RESERVED (FDO-27.0)		NC
28	KISSING PRIMARY TEETH		NC

29	MISSING PERM TOOTH		NO
30	MISSING PERM TOOTH		NO
31	MISSING PERM TOOTH		NO
32	MISSING PERM TOOTH		NO
33	MISSXG PERM TOOTH		NO
34	MISSING PERM TOOTH		NO
35	MISSING PERM TOOTH		NO
36	MISSING PERM TOOTH		NO
-- >I	MISSING PERM TOOTH		NO
36	MISSING PERM TOOTH		NO
35	MISSING PERM TOOTH		SO
40	MISSING PERM TOOTH		NO
41	MISSING PERM TOOTH		NO
42	MISSING PERM TOOTH		NO
43	MISSXG PERM TOOTH		NO
44	MISSING PERM TOOTH		NO
45	MISSING PERM TOOTH		NO
46	MISSING PER.? TOOTH		NO
47	MISSING PERM TOOTH		NO
48	MISSING PERM TOOTH		NO
49	MISSING PERK TOCTH		NO
53	MISSXG PERM TOCTH		NO
51	MISSING PERM TOOTH		NO
52	MISSING PERM TOOTH		NO
53	MISSING PERM TOOTH		NO
54	MISSING PERM TOOTH		NO
55	MISSING PERM TOOTH		NO
55	MISSING PERM TOOTH		NO
57	MISSING PERM TOOTH		NO
58	MISSZNG PERM TOOTH		NO
59	MISSING PERM TOOTH		NO
60	MISSING PERM TOOTH		NO
61	MISSING PERM TOOTH		NO
62	QUANDRANT		NO

63	TOOTH POCKET MEASURE		NO
64	FILLER-NATIONAL		YES

RECORD NAME: AMBULANCE CERT RECORD RECORD TYPE: *GAQ*

- o Not Required by Medicaid
- o Must follcw FBC - FD0
- o Must be followed by GCO - XA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "GA0"	c-24	GAC
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		NC
04	RESERVED (GA0-04.0)		NO
05	PATIENTS WEIGHT		NC
06	HOSPITAL ADMIT		NC
07	TYPE OF TRANSPORT		NC
08	BED CONFINED-BEFORE		NC
09	BED CONFINED-AFTER		NO
10	MOVED BY STRETCHER		NC
11	UNCONSCIOUS/SHOCK		NC
12	EMERGENCY SITUATION		NO
13	PHYSICAL RESTRAINTS		NO
14	VISIBLE HEMORRHAGING		NC
15	TRANSPORTED TO/FOR		NO
16	MEDICALLY NECESSARY		NC
17	MILES		NC
18	ORIGIN INFO		NO
19	DESTINATION INFO		NC
20	PURPOSE OF ROUND TRIP		NO
2i	PURPOSE OF STRETCHER		NC
22	PATIENT DISCHARGED		NC
23	PATIENT ADMITTED		NO
24	SERVICES AVAILABLE		NC
25	FILLER-NATIONAL		YES
26	FILLER-LOCAL		YES

RECORD NAME: **CHIROPRACTIC** CERT RECORD **RECORD TYPE: GC0**

- Not Required by Medicaid
- Must follow FD0 - GA0
- Must be followed by GD0 - XA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "GC0"	C-24	GC0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		NO
04	RESERVED (GC0-04.0)		NO
05	INITIAL TREATMENT DATE		NO
06	DATE OF LAST X-RAY		NO
07	NO IN SERIES		NO
08	LEVEL OF SUBLUXATION		NO
09	TREATMENT MONTHS/YEARS		NO
10	NO TREATMENTS - MONTH		NO
11	NATURE CF CONDITION		NO
12	DATE OF MANIFESTATION		NO
13	COMPLICATION IND		NO
14	SYMPTOMS DESCRIPTION		NO
15	X-RAY IND		NO
16	FILLER-NATIONAL		YES
17	FILLER-LOCAL		YES

RECORD NAME: CERTIFICATION RECORD "DURABLE MEDICAL EQUIPMENT" RECORDTYPE: GDO

- Not Required by Medicaid
- Must follow FB0 - GCO
- Must be foilowed by GD1 - XA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "GDO"	C-24	GD0
02	SEQUENCE NO	c-21	YES
03	SAT CONTROL NO		NO
04	CERTIFICATION TYPE		NC
	MEDICAL NECESSITY		NO
	PROGNOSIS		NC
	HCPCS PROCEDURE CODE		NC
	AMBULATORY		NC
	AMBULATION/THERAPY		NO
10	CCWINED BED/CHAIR		NO
11	RCOM CONFINED		NO
12	AMBULATION/MOBILITY		NO
13	BODY POSITIONING		NO
14	RESPIRATORY/OTHER		NO
15	BREATHING IMPAIRED		NO
16	FREQ/IMMED CHANGES		NO
17	OPERATE CONTROLS		NO
18	SIDERAILS PART/BED		NO
19	OWNS EQUIPMENT		NO
20	MATTRESS/SIDERAILS		NO
21	EQUIPMENT/ASSISTANCE		NO
22	ORTHOPEDIC IMPAIR		NO
23	PLANNED REGIMEN		NO
24	DECUBITUS ULCERS		NO
25	EQUIPMENT USE		NO
26	INSULIN DEPENDENT		NO
27	DIABETIC CONTROL		NO
28	APNEA EPISODES		NO

29	SURGERY ALTERNATIVE		NO
30	TOTAL KNEE REPLACE		NO
31	DATE SURGERY		NO
32	DATE CPM		NO
33	LYMPHEDEMA		NO
34	ORDERING PROV LAST		NO
35	ORDERING PROV FIRST		NO
36	ORDERING PROV MI		NO
37	ORDERING PROV ID		NO
38	ORDERING PROV PHONE		NO
39	DATE CERTIFICATION		NO
40	CERTIFICATION ON FILE		NO
41	DIAGNOSIS CODE-1		NO
42	DIAGNOSIS CODE-2		NO
43	DIAGNOSIS CODE-3		NO
44	DIAGNOSIS CODE-4		NO
45	NURSING HOME IND		NO
46	NH FROM DATE		NO
47	NH TO DATE		NO
48	RESPIRATORY TRACT		NO
49	SUPV OF EQUIPMENT USE		NO
50	PROPEL/LIFT CHAIR		NO
51	LEG ELEVATION		NO
52	PATIENT WEIGHT		NO
53	RECLINING WHEELCHAIR		NO
54	MANUAL OPERATION		NO
55	SIDE TRANSFER CHAIR		NO
56	FILLER-NATIONAL		YES
57	FILLER-LOCAL		YES

RECORD NAME: **CERTIFICATION RECORD** RECORDTYPE: GD1.
"NARRATIVE INFORMATION FOR DME"

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD IC "GD1"	C-24	GD1
02	SEQUENCE NO	c-21	YES
03	PAT CONTROL NO		NO
	NARRATIVE		NO
05	FILLER-NATIONAL		YES
06	FILLER-LOCAL		YES

RECORD NAME: CERTIFICATION RECORD "ENTERAL NUTRITION THERAPY" RECORD TYPE: GEC

- Not Required by Medicaid
- Must follow FB0 - GD1
- Must be followed by GP0 - XA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "GE0"	C-24	GEC
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		NO
04	CERTIFICATION TYPE		NO
05	ONSET DT OF THERAPY		NO
06	THERAPY DURATION		NO
07	LAST CERT DATE		NO
08	NO OF MONTHS CERT		NO
09	DT LAST SEEN BY PHY		NO
10	NON VISIT IND		NO
11	PAT AGE		NO
12	PAT HEIGHT		NO
13	PAT WEIGHT		NO
14	LEVEL OF CONS IND		NO
15	AMBULATORY IND		NO
16	OTHER FORMS OF NUTR IND		NO
17	METHOD ADMIN IND		NO
18	ADMIN TECH IND		NO
19	TOTAL CAL PER DAY		NO
20	PRODUCT NAME 1		NO
21	CAL PER PRODUCT 1		NO
22	HCPCS PROCEDURE CODE		NO
23	HCPCS MODIFIER 1		NO
24	HCPCS MODIFIER 2		NO
25	ENTERAL FREQ FED 1		NO
26	NARRATIVE FIELD		NO
27	PRODUCT NAME 2		NO
28	CAL PER PRODUCT 2		NO

29	ENTERAL FREQ FED 2		NO
30	FILLER-NATIONAL		YES
31	FILLER-LOCAL		YES

RECORD NAME: CKRTIFICATION RECORD RECORD TYPE: GPO
"PARENTERAL NUTRITION THERAPY"

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "GPO	C-24	GOO
02	SEQUENCE NO	c-21	YES
03	SAT CONTROL NO		NO
04	CERTIFICATION TYPE		KO
05	ONSET DT OF THERAPY		NO
06	THERAPY DURATION		NO
07	LAST CERT DATE		NO
06	NO OF MONTHS CERT		NO
09	DT LAST SEEN BY PHY		NO
13	NON VISIT IND		NO
11	PAT AGE		KO
12	PAT HEIGHT		NO
13	PAT WEIGHT		KO
14	LEVEL OF CONS IN3		KO
15	AMBULATORY IND		NO
16	OTHER FORMS OF NUTR IND		NO
17	TYPE OF MIX IND		NO
18	PARENTERAL FREQ FED		NO
19	ECPCS PROCEDURE CODE		NO
23	ECPCS MODIFIER 1		NO
2i	ECPCS MODIFIER 2		NO
22	AMINO ACID NAME		NO
23	AMINO ACID VOLUME		NO
24	AMINO ACID CONC		NO
25	AMINO ACZD WEIGHT		NO
26	DEXTROSE VOLUME		NO
27	DEXTROSE CONC		NO
28	LIPIDS VOLUME		NO

29	LIPIDS CONC		NO
30	LIPIDS FREQ		NO
31	NARRATIVE FIELD		NO
32	ADMIN TECH IND		NO
33	FILLER-NATIONAL		YES
34	FILLER-LOCAL		YES

RECORD NAME: CERTIFICATION RECORD "DMEPOS ITEMS" RECORD TYPE: GUO

c Not Required by Medicaid
c Must follow FBO - GPO
c Must be foilowed by GXO - XAO

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "GUO"	c-24	GUO
02	SEQUENCE NO	c-21	YES
03	PAT CONTROL NO		NO
04	CERTIFICATION TYPE		NO
c5	PLACE OF SERVICE		NO
06	REPLACEMENT ITEM		SO
07	HCPCS PROCEDURE CODE		NO
08	HCTCS MODIFIER		NO
09	WARRANTY REPLY		NO
10	WARRANTY LENGTE		NO
11	WARRANTY TYPE		NO
12	DIAGNOSIS CODE-1		NO
13	DIAGNOSIS CODE-2		NO
14	DIAGNOSIS CODE-3		NO
15	DIAGNOSIS CODE-4		NO
16	PATIENT HEIGHT		NO
17	PATIENT WEIGHT		NO
18	DT LAST MEDICAL EXAM		NO
19	INITIAL DATZ		NO
20	REV RECERT DATE		NO
21	LENGTH OF NEED		NO
22	DATE CERT SIGNED		NO
23	ORDERING PRGV PHONE		NO
24	CERT ON FILE		NO
25	CERT FORM NUMBER		NO
26	REPLY ALN L01 N01		NO
27	REPLY ALN L01 N02		NO
28	REPLY ALN LO1 N03		NO

29	REPLY ALN L01 N04		NO
30	REPLY ALN L01 N05		NO
31	REPLY ALN L01 N06		NO
32	REPLY ALN L01 N07		NO
33	REPLY ALN LO1 N08		NO
34	REPLY ALN L01 N09		NO
35	REPLY ALN L01 N010		NO
36	REPLY ALN L01 N011		NO
37	REPLY ALN L01 N012		NO
38	REPLY ALN L01 N013		NO
39	REPLY ALN L01 N014		NO
40	REPLY ALN L01 N015		NO
41	REPLY ALN L01 N016		NO
42	REPLY ALN L01 N017		NO
43	REPLY ALN L01 N018		NO
44	REPLY ALN L01 N019		NO
45	REPLY ALN L01 N020		NO
46	REPLY ALN L01 N021		NO
47	REPLY ALN L01 N022		NO
48	REPLY ALN LO1 N023		NO
49	REPLY ALN LO1 N024		NO
50	REPLY ALN L05 N01		NO
51	REPLY ALN L05 N02		NO
52	REPLY ALN L05 N03		NO
53	REPLY ALN L08 N01		NO
54	REPLY ALN LO8 N02		NO
55	REPLY ALN L08 N03		NO
56	REPLY ALN L08 N04		NO
57	REPLY ALN L20 N01		NO
58	REPLY ALN L60 N01		NO
59	REPLY NUM L01 N01		NO
60	REPLY NUM L01 N02		NO
61	REPLY NUM L01 N03		NO
62	REPLY NUM L04 N01		NO

64	REPLY NUM L04 N03		NO
65	REPLY NUM LO4 N04		NO
66	REPLY NUM LO4 N05		NO
67	REPLY NUM L04 N06		NO
68	REPLY NUM LO4 N07		NO
69	REPLY PCT L04 N01		NO
70	REPLY PCP L04 NO2		NO
71	REPLY PCT L04 N03		NO
72	FILLER-NATIONAL		YES
73	FILLER-MCAL		YES

RECORD **NAME: CKRTIFICATION** RECORD RECORD **TYPE: GX0**
"MEDICAL NECESSITY FOR *OXYGEN"*

- **Not** Required **by Medicaid**
- Must follow FB0 - GU0
- **Must be** followed by GX1 - XA0

Field No.	Field Name	Table Value	Encounter Req.
01	RECORD ID "GX0"	C-24	GX0
02	SEQUENCE NO	C-21	YES
03	PAT CONTROL NO		NO
04	CERTIFICATION TYPE		NO
05	OXYGEN SYSTEM		NO
06	LENGTH OF NEED		NO
07	EQUIPMENT TYPE 1		NO
08	EQUIPMENT TYPE 2		NO
09	EQUIPMENT REASON		NO
10	PRESCRIBED FROM DATE		NO
11	PRESCRIBED TO DATE		NO
12	DATE PRESCRIBED		NO
13	DATE EVALUATED		NO
14	OXY FLOW RATE		NO
15	FREQUENCY OF USE		NO
16	DURATION		NO
17	OTHER		NO
18	ARTERIAL BLOOD GAS		NO
19	OXIMETRY		NO
20	DATE TESTED		NO
21	TEST FACILITY NAME		NO
22	TEST CONDITIONS		NO
23	CLINICAL FINDINGS		NO
24	PORT OXY FLOW RATE		NO
25	ORDERING PROV ID		NO
26	ORDERING PROV PHONE		NO
27	DIAGNOSIS CODE-1		NO
28	DIAGNOSIS CODE-2		NO

29	DIAGNOSIS CODE-3		NO
30	DIAGNOSIS CODE-4		NO
31	CERT CN FILE		NO
32	DELIVERY SYSTEM TYPE		NO
33	FILLER-NATIONAL		YES