All Medicare data for LTCS participants was supplied to the Center for Demographic Studies (CDS) by the Health Care Financing Administration. CDS has not altered the data except to blank out or remove confidential fields and to change packed decimal, integer binary, zoned decimal, and EBCDIC formats into ASCII character formats.

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<td>CONTAINS 100% RAW INSTITUTIONAL CLAIMS DATA AND PHYSICIAN/SUPPLIER PART B PAYMENT RECORDS (1984-1990)</td>
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<td>3. BENEFICIARY IDENTIFICATION CODE</td>
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<td>THE CODE IDENTIFYING THE TYPE OF RELATIONSHIP BETWEEN AN INDIVIDUAL AND A PRIMARY SOCIAL SECURITY ADMINISTRATION (SSA) BENEFICIARY.</td>
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<td>STANDARD ALIAS: BENE_IDENT_CD</td>
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<td>COMMON ALIAS: BIC</td>
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</table>
SAS ALIAS: BIC

CODES:
A  = PRIMARY CLAIMANT
B  = AGED WIFE, AGE 62 OR OVER (1ST CLAIMANT)
B1 = AGED HUSBAND, AGE 62 OR OVER (1ST CLAIMANT)
B2 = YOUNG WIFE, WITH A CHILD IN HER CARE (1ST CLAIMANT)
B3 = AGED WIFE (2ND CLAIMANT)
B4 = AGED HUSBAND (2ND CLAIMANT)
B5 = YOUNG WIFE (2ND CLAIMANT)
B6 = DIVORCED WIFE, AGE 62 OR OVER (1ST CLAIMANT)
B7 = YOUNG WIFE (3RD CLAIMANT)
B8 = AGED WIFE (3RD CLAIMANT)
B9 = DIVORCED WIFE (2ND CLAIMANT)
BA = AGED WIFE (4TH CLAIMANT)
BD = AGED WIFE (5TH CLAIMANT)
BG = AGED HUSBAND (3RD CLAIMANT)
BH = AGED HUSBAND (4TH CLAIMANT)
BJ = AGED HUSBAND (5TH CLAIMANT)
BK = YOUNG WIFE (4TH CLAIMANT)
BL = YOUNG WIFE (5TH CLAIMANT)
BN = DIVORCED WIFE (3RD CLAIMANT)
BP = DIVORCED WIFE (4TH CLAIMANT)
BQ = DIVORCED WIFE (5TH CLAIMANT)
BR = DIVORCED HUSBAND (1ST CLAIMANT)
BT = DIVORCED HUSBAND (2ND CLAIMANT)
BW = YOUNG HUSBAND (2ND CLAIMANT)
BY = YOUNG HUSBAND (1ST CLAIMANT)
C1-C9,CA-CK = CHILD (INCLUDES MINOR, STUDENT OR DISABLED CHILD)
D  = AGED WIDOW, 60 OR OVER (1ST CLAIMANT)
D1 = AGED WIDOWER, AGE 60 OR OVER (1ST CLAIMANT)
D2 = AGED WIDOW (2ND CLAIMANT)
D3 = AGED WIDOWER (2ND CLAIMANT)
D4 = WIDOW (REMARRIED AFTER ATTAINMENT OF AGE 60) (1ST CLAIMANT)
D5 = WIDOWER (REMARRIED AFTER ATTAINMENT OF
AGE 60) (1ST CLAIMANT)
D6 = SURVIVING DIVORCED WIFE, AGE 60 OR OVER
(1ST CLAIMANT)
D7 = SURVIVING DIVORCED WIFE (2ND CLAIMANT)
D8 = AGED WIDOW (3RD CLAIMANT)
D9 = REMARRIED WIDOW (2ND CLAIMANT)
DA = REMARRIED WIDOW (3RD CLAIMANT)
DD = AGED WIDOW (4TH CLAIMANT)
DG = AGED WIDOW (5TH CLAIMANT)
DH = AGED WIDOWER (3RD CLAIMANT)
DJ = AGED WIDOWER (4TH CLAIMANT)
DK = AGED WIDOWER (5TH CLAIMANT)
DL = REMARRIED WIDOW (4TH CLAIMANT)
DM = SURVIVING DIVORCED HUSBAND (2ND
CLAIMANT)
DN = REMARRIED WIDOW (5TH CLAIMANT)
DP = REMARRIED WIDOWER (2ND CLAIMANT)
DQ = REMARRIED WIDOWER (3RD CLAIMANT)
DR = REMARRIED WIDOWER (4TH CLAIMANT)
DS = SURVIVING DIVORCED HUSBAND (3RD
CLAIMANT)
DT = REMARRIED WIDOWER (5TH CLAIMANT)
DV = SURVIVING DIVORCED WIFE (3RD CLAIMANT)
DW = SURVIVING DIVORCED WIFE (4TH CLAIMANT)
DX = SURVIVING DIVORCED HUSBAND (4TH
CLAIMANT)
DY = SURVIVING DIVORCED WIFE (5TH CLAIMANT)
DZ = SURVIVING DIVORCED HUSBAND (5TH
CLAIMANT)
E = MOTHER (WIDOW) (1ST CLAIMANT)
E1 = SURVIVING DIVORCED MOTHER (1ST
CLAIMANT)
E2 = MOTHER (WIDOW) (2ND CLAIMANT)
E3 = SURVIVING DIVORCED MOTHER (2ND
CLAIMANT)
E4 = FATHER (WIDOWER) (1ST CLAIMANT)
E5 = SURVIVING DIVORCED FATHER (WIDOWER)
(1ST CLAIMANT)
E6 = FATHER (WIDOWER) (2ND CLAIMANT)
E7 = MOTHER (WIDOW) (3RD CLAIMANT)
E8 = MOTHER (WIDOW) (4TH CLAIMANT)
E9 = SURVIVING DIVORCED FATHER (WIDOWER)
(2ND CLAIMANT)
EA = MOTHER (WIDOW) (5TH CLAIMANT)
EB = SURVIVING DIVORCED MOTHER (3RD CLAIMANT)
EC = SURVIVING DIVORCED MOTHER (4TH CLAIMANT)
ED = SURVIVING DIVORCED MOTHER (5TH CLAIMANT)
EF = FATHER (WIDOWER) (3RD CLAIMANT)
EG = FATHER (WIDOWER) (4TH CLAIMANT)
EH = FATHER (WIDOWER) (5TH CLAIMANT)
EJ = SURVIVING DIVORCED FATHER (3RD CLAIMANT)
EK = SURVIVING DIVORCED FATHER (4TH CLAIMANT)
EM = SURVIVING DIVORCED FATHER (5TH CLAIMANT)
F1 = FATHER
F2 = MOTHER
F3 = STEPFATHER
F4 = STEPMOTHER
F5 = ADOPTING FATHER
F6 = ADOPTING MOTHER
F7 = SECOND ALLEGED FATHER
F8 = SECOND ALLEGED MOTHER
J1 = PRIMARY PROUTY ENTITLED TO HIB (LESS THAN 3 Q.C.) (GENERAL FUND)
J2 = PRIMARY PROUTY ENTITLED TO HIB (OVER 2 Q.C.) (RSI TRUST FUND)
J3 = PRIMARY PROUTY NOT ENTITLED TO HIB (LESS THAN 3 Q.C.) (GENERAL FUND)
J4 = PRIMARY PROUTY NOT ENTITLED TO HIB (OVER 2 Q.C.) (RSI TRUST FUND)
K1 = PROUTY WIFE ENTITLED TO HIB (LESS THAN 3 Q.C.) (GENERAL FUND) (1ST CLAIMANT)
K2 = PROUTY WIFE ENTITLED TO HIB (OVER 2 Q.C.) (RSI TRUST FUND) (1ST CLAIMANT)
K3 = PROUTY WIFE NOT ENTITLED TO HIB (LESS THAN 3 Q.C.) (GENERAL FUND) (1ST CLAIMANT)
K4 = PROUTY WIFE NOT ENTITLED TO HIB (OVER 2 Q.C.) (RSI TRUST FUND) (1ST CLAIMANT)
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<th>CLAIMANT</th>
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<td>K7 = PROUTY WIFE NOT ENTITLED TO HIB (LESS THAN 3 Q.C.) (GENERAL FUND) (2ND CLAIMANT)</td>
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<td>K8 = PROUTY WIFE NOT ENTITLED TO HIB (OVER 2 Q.C.) (RSI TRUST FUND) (2ND CLAIMANT)</td>
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<td>K9 = PROUTY WIFE ENTITLED TO HIB (LESS THAN 3 Q.C.) (GENERAL FUND) (3RD CLAIMANT)</td>
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<td>KA = PROUTY WIFE ENTITLED TO HIB (OVER 2 Q.C.) (RSI TRUST FUND) (3RD CLAIMANT)</td>
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<td>KB = PROUTY WIFE NOT ENTITLED TO HIB (LESS THAN 3 Q.C.) (GENERAL FUND) (3RD CLAIMANT)</td>
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<tr>
<td>KC = PROUTY WIFE NOT ENTITLED TO HIB (OVER 2 Q.C.) (RSI TRUST FUND) (3RD CLAIMANT)</td>
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<td>KD = PROUTY WIFE ENTITLED TO HIB (LESS THAN 3 Q.C.) (GENERAL FUND) (4TH CLAIMANT)</td>
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<tr>
<td>KE = PROUTY WIFE ENTITLED TO HIB (OVER 2 Q.C.) (4TH CLAIMANT)</td>
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<tr>
<td>KF = PROUTY WIFE NOT ENTITLED TO HIB (LESS THAN 3 Q.C.) (4TH CLAIMANT)</td>
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<tr>
<td>KG = PROUTY WIFE NOT ENTITLED TO HIB (OVER 2 Q.C.) (4TH CLAIMANT)</td>
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<td>KH = PROUTY WIFE ENTITLED TO HIB (LESS THAN 3 Q.C.) (5TH CLAIMANT)</td>
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<td>KJ = PROUTY WIFE ENTITLED TO HIB (OVER 2 Q.C.) (5TH CLAIMANT)</td>
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<td>KM = PROUTY WIFE NOT ENTITLED TO HIB (OVER 2 Q.C.) (5TH CLAIMANT)</td>
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<td>M = UNINSURED—NOT QUALIFIED FOR DEEMED HIB</td>
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<td>M1 = UNINSURED—QUALIFIED BUT REFUSED HIB</td>
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<tr>
<td>T = UNINSURED—ENTITLED TO HIB UNDER DEEMED OR RENAL PROVISIONS</td>
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<td>TA = MQGE (PRIMARY CLAIMANT)</td>
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TB = MQGE AGED SPOUSE (FIRST CLAIMANT)
TC = MQGE DISABLED ADULT CHILD (FIRST CLAIMANT)
TD = MQGE AGED WIDOW(ER) (FIRST CLAIMANT)
TE = MQGE YOUNG WIDOW(ER) (FIRST CLAIMANT)
TF = MQGE PARENT (MALE)
TG = MQGE AGED SPOUSE (SECOND CLAIMANT)
TH = MQGE AGED SPOUSE (THIRD CLAIMANT)
TJ = MQGE AGED SPOUSE (FOURTH CLAIMANT)
TK = MQGE AGED SPOUSE (FIFTH CLAIMANT)
TL = MQGE AGED WIDOW(ER) (SECOND CLAIMANT)
TM = MQGE AGED WIDOW(ER) (THIRD CLAIMANT)
TN = MQGE AGED WIDOW(ER) (FOURTH CLAIMANT)
TP = MQGE AGED WIDOW(ER) (FIFTH CLAIMANT)
TQ = MQGE PARENT (FEMALE)
TR = MQGE YOUNG WIDOW(ER) (SECOND CLAIMANT)
TS = MQGE YOUNG WIDOW(ER) (THIRD CLAIMANT)
TT = MQGE YOUNG WIDOW(ER) (FOURTH CLAIMANT)
TU = MQGE YOUNG WIDOW(ER) (FIFTH CLAIMANT)
TV = MQGE DISABLED WIDOW(ER) FIFTH CLAIMANT
TW = MQGE DISABLED WIDOW(ER) FIRST CLAIMANT
TX = MQGE DISABLED WIDOW(ER) SECOND CLAIMANT
TY = MQGE DISABLED WIDOW(ER) THIRD CLAIMANT
TZ = MQGE DISABLED WIDOW(ER) FOURTH CLAIMANT
T2-T9 = DISABLED CHILD (SECOND TO NINTH CLAIMANT)
W = DISABLED WIDOW, AGE 50 OR OVER (1ST CLAIMANT)
W1 = DISABLED WIDOWER, AGE 50 OR OVER (1ST CLAIMANT)
W2 = DISABLED WIDOW (2ND CLAIMANT)
W3 = DISABLED WIDOWER (2ND CLAIMANT)
W4 = DISABLED WIDOW (3RD CLAIMANT)
W5 = DISABLED WIDOWER (3RD CLAIMANT)
W6 = DISABLED SURVIVING DIVORCED WIFE (1ST CLAIMANT)
W7 = DISABLED SURVIVING DIVORCED WIFE (2ND CLAIMANT)
W8 = DISABLED SURVIVING DIVORCED WIFE (3RD CLAIMANT)
W9 = DISABLED WIDOW (4TH CLAIMANT)
WB = DISABLED WIDOWER (4TH CLAIMANT)
WC = DISABLED SURVIVING DIVORCED WIFE (4TH
CLAIMANT)
WF = DISABLED WIDOW (5TH CLAIMANT)
WG = DISABLED WIDOWER (5TH CLAIMANT)
WJ = DISABLED SURVIVING DIVORCED WIFE (5TH CLAIMANT)
WR = DISABLED SURVIVING DIVORCED HUSBAND (1ST CLAIMANT)
WT = DISABLED SURVIVING DIVORCED HUSBAND (2ND CLAIMANT)

SOURCE:
SSA

4. EQUATED BENEFICIARY IDENTIFICATION CODE (BIC) CHAR 2 9 10 THIS CODE SPECIFIES THE TYPE OF BENEFICIARY FOR CASH PAYMENT PROGRAMS AND IDENTIFIES THE TYPE OF RELATIONSHIP BETWEEN THE INDIVIDUAL AND PRIMARY BENEFICIARY WHEN THE INDIVIDUAL IS QUALIFIED UNDER ANOTHER’S ACCOUNT. THE CODE IS EQUATED TO A COMMON BIC. FOR EXAMPLE, THE RECORDS FOR A WIFE (BIC B) WHO BECOMES A WIDOW (BIC D) IN THE FILE YEAR WOULD HAVE ALL RECORDS CODED TO THE FIRST BIC.

COMMON ALIAS: BIC

CODES:
A = PRIMARY CLAIMANT
B = AGED WIFE, AGE 62 OR OVER (1ST CLAIMANT)
B1 = AGED HUSBAND, AGE 62 OR OVER (1ST CLAIMANT)
B2 = YOUNG WIFE, WITH A CHILD IN HER CARE (1ST CLAIMANT)
B3 = AGED WIFE (2ND CLAIMANT)
B4 = AGED HUSBAND (2ND CLAIMANT)
B5 = YOUNG WIFE (2ND CLAIMANT)
B6 = DIVORCED WIFE, AGE 62 OR OVER (1ST CLAIMANT)
B7 = YOUNG WIFE (3RD CLAIMANT)
B8 = AGED WIFE (3RD CLAIMANT)
B9 = DIVORCED WIFE (2ND CLAIMANT)
BA = AGED WIFE (4TH CLAIMANT)
BD = AGED WIFE (5TH CLAIMANT)
BG = AGED HUSBAND (3RD CLAIMANT)
BH = AGED HUSBAND (4TH CLAIMANT)
BJ = AGED HUSBAND (5TH CLAIMANT)
BK = YOUNG WIFE (4TH CLAIMANT)
BL = YOUNG WIFE (5TH CLAIMANT)
BN = DIVORCED WIFE (3RD CLAIMANT)
BP = DIVORCED WIFE (4TH CLAIMANT)
BQ = DIVORCED WIFE (5TH CLAIMANT)
BR = DIVORCED HUSBAND (1ST CLAIMANT)
BT = DIVORCED HUSBAND (2ND CLAIMANT)
BW = YOUNG HUSBAND (2ND CLAIMANT)
BY = YOUNG HUSBAND (1ST CLAIMANT)
C1-C9, CA-CK = CHILD (INCLUDES MINOR, STUDENT OR DISABLED CHILD)
D = AGED WIDOW, 60 OR OVER (1ST CLAIMANT)
D1 = AGED WIDOWER, AGE 60 OR OVER (1ST CLAIMANT)
D2 = AGED WIDOW (2ND CLAIMANT)
D3 = AGED WIDOWER (2ND CLAIMANT)
D4 = WIDOW (REMARIED AFTER ATTAINMENT OF AGE 60) (1ST CLAIMANT)
D5 = WIDOWER (REMARIED AFTER ATTAINMENT OF AGE 60) (1ST CLAIMANT)
D6 = SURVIVING DIVORCED WIFE, AGE 60 OR OVER (1ST CLAIMANT)
D7 = SURVIVING DIVORCED WIFE (2ND CLAIMANT)
D8 = AGED WIDOW (3RD CLAIMANT)
D9 = REMARRIED WIDOW (2ND CLAIMANT)
DA = REMARRIED WIDOW (3RD CLAIMANT)
DD = AGED WIDOW (4TH CLAIMANT)
DG = AGED WIDOW (5TH CLAIMANT)
DH = AGED WIDOWER (3RD CLAIMANT)
DJ = AGED WIDOWER (4TH CLAIMANT)
DK = AGED WIDOWER (5TH CLAIMANT)
DL = REMARRIED WIDOW (4TH CLAIMANT)
DM = SURVIVING DIVORCED HUSBAND (2ND CLAIMANT)
DN = REMARRIED WIDOW (5TH CLAIMANT)
DP = REMARRIED WIDOWER (2ND CLAIMANT)
DQ = REMARRIED WIDOWER (3RD CLAIMANT)
DR = REMARRIED WIDOWER (4TH CLAIMANT)
DS = SURVIVING DIVORCED HUSBAND (3RD CLAIMANT)
DT = REMARRIED WIDOWER (5TH CLAIMANT)
DV = SURVIVING DIVORCED WIFE (3RD CLAIMANT)
DW = SURVIVING DIVORCED WIFE (4TH CLAIMANT)
DX = SURVIVING DIVORCED HUSBAND (4TH CLAIMANT)
DY = SURVIVING DIVORCED WIFE (5TH CLAIMANT)
DZ = SURVIVING DIVORCED HUSBAND (5TH CLAIMANT)
E  = MOTHER (WIDOW) (1ST CLAIMANT)
E1 = SURVIVING DIVORCED MOTHER (1ST CLAIMANT)
E2 = MOTHER (WIDOW) (2ND CLAIMANT)
E3 = SURVIVING DIVORCED MOTHER (2ND CLAIMANT)
E4 = FATHER (WIDOWER) (1ST CLAIMANT)
E5 = SURVIVING DIVORCED FATHER (WIDOWER) (1ST CLAIMANT)
E6 = FATHER (WIDOWER) (2ND CLAIMANT)
E7 = MOTHER (WIDOW) (3RD CLAIMANT)
E8 = MOTHER (WIDOW) (4TH CLAIMANT)
E9 = SURVIVING DIVORCED FATHER (WIDOWER) (2ND CLAIMANT)
EA = MOTHER (WIDOW) (5TH CLAIMANT)
EB = SURVIVING DIVORCED MOTHER (3RD CLAIMANT)
EC = SURVIVING DIVORCED MOTHER (4TH CLAIMANT)
ED = SURVIVING DIVORCED MOTHER (5TH CLAIMANT)
EF = FATHER (WIDOWER) (3RD CLAIMANT)
EG = FATHER (WIDOWER) (4TH CLAIMANT)
EH = FATHER (WIDOWER) (5TH CLAIMANT)
EJ = SURVIVING DIVORCED FATHER (3RD CLAIMANT)
EK = SURVIVING DIVORCED FATHER (4TH CLAIMANT)
EM = SURVIVING DIVORCED FATHER (5TH CLAIMANT)
F1 = FATHER
F2 = MOTHER
F3 = STEPFATHER
F4 = STEPMOTHER
F5 = ADOPTING FATHER
F6 = ADOPTING MOTHER
F7 = SECOND ALLEGED FATHER
F8 = SECOND ALLEGED MOTHER
J1 = PRIMARY PROUTY ENTITLED TO HIB
   (LESS THAN 3 Q.C.) (GENERAL FUND)
J2 = PRIMARY PROUTY ENTITLED TO HIB
   (OVER 2 Q.C.) (RSI TRUST FUND)
J3 = PRIMARY PROUTY NOT ENTITLED TO HIB
   (LESS THAN 3 Q.C.) (GENERAL FUND)
J4 = PRIMARY PROUTY NOT ENTITLED TO HIB
   (OVER 2 Q.C.) (RSI TRUST FUND)
K1 = PROUTY WIFE ENTITLED TO HIB (LESS THAN
   3 Q.C.) (GENERAL FUND) (1ST CLAIMANT)
K2 = PROUTY WIFE ENTITLED TO HIB (OVER
   Q.C.) (RSI TRUST FUND) (1ST CLAIMANT)
K3 = PROUTY WIFE NOT ENTITLED TO HIB (LESS
   THAN 3 Q.C.) (GENERAL FUND) (1ST
   CLAIMANT)
K4 = PROUTY WIFE NOT ENTITLED TO HIB (OVER
   2 Q.C.) (RSI TRUST FUND) (1ST
   CLAIMANT)
K5 = PROUTY WIFE ENTITLED TO HIB (LESS THAN
   3 Q.C.) (GENERAL FUND) (2ND CLAIMANT)
K6 = PROUTY WIFE ENTITLED TO HIB (OVER 2
   Q.C.) (RSI TRUST FUND) (2ND CLAIMANT)
K7 = PROUTY WIFE NOT ENTITLED TO HIB (LESS
   THAN 3 Q.C.) (GENERAL FUND) (2ND
   CLAIMANT)
K8 = PROUTY WIFE NOT ENTITLED TO HIB (OVER
   2 Q.C.) (RSI TRUST FUND) (2ND
   CLAIMANT)
K9 = PROUTY WIFE ENTITLED TO HIB (LESS THAN
   3 Q.C.) (GENERAL FUND) (3RD CLAIMANT)
KA = PROUTY WIFE ENTITLED TO HIB (OVER 2
   Q.C.) (RSI TRUST FUND) (3RD CLAIMANT)
KB = PROUTY WIFE NOT ENTITLED TO HIB (LESS
   THAN 3 Q.C.) (GENERAL FUND) (3RD
   CLAIMANT)
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<th>Code</th>
<th>Description</th>
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<td>Proud Wife Not Entitled to Hib (Over 2 Q.C.) (RSI Trust Fund) (3rd Claimant)</td>
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<td>KD</td>
<td>Proud Wife Entitled to Hib (Less Than 3 Q.C.) (General Fund) (4th Claimant)</td>
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<tr>
<td>KE</td>
<td>Proud Wife Entitled to Hib (Over 2 Q.C.) (4th Claimant)</td>
</tr>
<tr>
<td>KF</td>
<td>Proud Wife Not Entitled to Hib (Less Than 3 Q.C.) (4th Claimant)</td>
</tr>
<tr>
<td>KG</td>
<td>Proud Wife Not Entitled to Hib (Over 2 Q.C.) (4th Claimant)</td>
</tr>
<tr>
<td>KH</td>
<td>Proud Wife Entitled to Hib (Less Than 3 Q.C.) (5th Claimant)</td>
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<td>KJ</td>
<td>Proud Wife Entitled to Hib (Over 2 Q.C.) (5th Claimant)</td>
</tr>
<tr>
<td>KL</td>
<td>Proud Wife Not Entitled to Hib (Less Than 3 Q.C.) (5th Claimant)</td>
</tr>
<tr>
<td>KM</td>
<td>Proud Wife Not Entitled to Hib (Over 2 Q.C.) (5th Claimant)</td>
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<tr>
<td>M</td>
<td>Uninsured—Not Qualified for Deemed Hib</td>
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<td>M1</td>
<td>Uninsured—Qualified but Refused Hib</td>
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<td>T</td>
<td>Uninsured—Entitled to Hib Under Deemed or Renal Provisions</td>
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<tr>
<td>TA</td>
<td>MQGE (Primary Claimant)</td>
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<tr>
<td>TB</td>
<td>MQGE Aged Spouse (First Claimant)</td>
</tr>
<tr>
<td>TC</td>
<td>MQGE Disabled Adult Child (First Claimant)</td>
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<tr>
<td>TD</td>
<td>MQGE Aged Widow(er) (First Claimant)</td>
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<td>TE</td>
<td>MQGE Young Widow(er) (First Claimant)</td>
</tr>
<tr>
<td>TF</td>
<td>MQGE Parent (Male)</td>
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<td>MQGE Aged Spouse (Second Claimant)</td>
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<td>MQGE Aged Spouse (Third Claimant)</td>
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<td>MQGE Aged Spouse (Fifth Claimant)</td>
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<td>MQGE Aged Widow(er) (Second Claimant)</td>
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<tr>
<td>TN</td>
<td>MQGE Aged Widow(er) (Fourth Claimant)</td>
</tr>
<tr>
<td>TP</td>
<td>MQGE Aged Widow(er) (Fifth Claimant)</td>
</tr>
<tr>
<td>TQ</td>
<td>MQGE Parent (Female)</td>
</tr>
<tr>
<td>TR</td>
<td>MQGE Young Widow(er) (Second Claimant)</td>
</tr>
<tr>
<td>TS</td>
<td>MQGE Young Widow(er) (Third Claimant)</td>
</tr>
<tr>
<td>TT</td>
<td>MQGE Young Widow(er) (Fourth Claimant)</td>
</tr>
<tr>
<td>TU</td>
<td>MQGE Young Widow(er) (Fifth Claimant)</td>
</tr>
</tbody>
</table>
TV = MQGE DISABLED WIDOW(ER) FIFTH CLAIMANT
TW = MQGE DISABLED WIDOW(ER) FIRST CLAIMANT
TX = MQGE DISABLED WIDOW(ER) SECOND CLAIMANT
TY = MQGE DISABLED WIDOW(ER) THIRD CLAIMANT
TZ = MQGE DISABLED WIDOW(ER) FOURTH CLAIMANT
T2-T9 = DISABLED CHILD (SECOND TO NINTH CLAIMANT)
W = DISABLED WIDOW, AGE 50 OR OVER (1ST CLAIMANT)
W1 = DISABLED WIDOWER, AGE 50 OR OVER (1ST CLAIMANT)
W2 = DISABLED WIDOW (2ND CLAIMANT)
W3 = DISABLED WIDOWER (2ND CLAIMANT)
W4 = DISABLED WIDOW (3RD CLAIMANT)
W5 = DISABLED WIDOWER (3RD CLAIMANT)
W6 = DISABLED SURVIVING DIVORCED WIFE (1ST CLAIMANT)
W7 = DISABLED SURVIVING DIVORCED WIFE (2ND CLAIMANT)
W8 = DISABLED SURVIVING DIVORCED WIFE (3RD CLAIMANT)
W9 = DISABLED WIDOW (4TH CLAIMANT)
WB = DISABLED WIDOWER (4TH CLAIMANT)
WC = DISABLED SURVIVING DIVORCED WIFE (4TH CLAIMANT)
WF = DISABLED WIDOW (5TH CLAIMANT)
WG = DISABLED WIDOWER (5TH CLAIMANT)
WJ = DISABLED SURVIVING DIVORCED WIFE (5TH CLAIMANT)
WR = DISABLED SURVIVING DIVORCED HUSBAND (1ST CLAIMANT)
WT = DISABLED SURVIVING DIVORCED HUSBAND (2ND CLAIMANT)

SOURCE:
SSA AND RRB BENEFICIARY RECORD SYSTEMS

5. STATE CODE CHAR 2 11 12

THIS FIELD SPECIFIES THE STATE OF RESIDENCE OF THE BENEFICIARY AND IS BASED ON THE MAILING ADDRESS USED FOR CASH BENEFITS OR THE MAILING ADDRESS USED FOR OTHER PURPOSES (FOR EXAMPLE, PREMIUM BILLING). THIS INFORMATION IS
MAINTAINED FROM CHANGE OF ADDRESS NOTICES
SENT IN BY THE BENEFICIARIES, AND IS APPENDED
TO THE RECORD AT TIME OF PROCESSING IN CENTRAL
OFFICE. THE CODING SYSTEM IS THE SSA SYSTEM,
NOT THE FEDERAL INFORMATION PROCESSING
STANDARD (FIPS).

STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD

<table>
<thead>
<tr>
<th>CODE</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>ALABAMA</td>
</tr>
<tr>
<td>02</td>
<td>ALASKA</td>
</tr>
<tr>
<td>03</td>
<td>ARIZONA</td>
</tr>
<tr>
<td>04</td>
<td>ARKANSAS</td>
</tr>
<tr>
<td>05</td>
<td>CALIFORNIA</td>
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<tr>
<td>05</td>
<td>COLORADO</td>
</tr>
<tr>
<td>07</td>
<td>CONNECTICUT</td>
</tr>
<tr>
<td>08</td>
<td>DELAWARE</td>
</tr>
<tr>
<td>09</td>
<td>DISTRICT OF COLUMBIA</td>
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<tr>
<td>10</td>
<td>FLORIDA</td>
</tr>
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<td>11</td>
<td>GEORGIA</td>
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<tr>
<td>12</td>
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<td>ILLINOIS</td>
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<td>28</td>
<td>NEBRASKA</td>
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<tr>
<td>29</td>
<td>NEVADA</td>
</tr>
<tr>
<td>30</td>
<td>NEW HAMPSHIRE</td>
</tr>
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<td>31</td>
<td>NEW JERSEY</td>
</tr>
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<td>32</td>
<td>NEW MEXICO</td>
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<tr>
<td>Field ID</td>
<td>Type</td>
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<tr>
<td>-----------</td>
<td>-------</td>
</tr>
<tr>
<td>6. COUNTY CODE</td>
<td>CHAR</td>
</tr>
<tr>
<td>7. ZIP CODE OF RESIDENCE</td>
<td>CHAR</td>
</tr>
<tr>
<td>8. DATE OF BIRTH</td>
<td>CHAR</td>
</tr>
<tr>
<td>9. AGE</td>
<td>NUM</td>
</tr>
<tr>
<td>10. SEX</td>
<td>CHAR</td>
</tr>
</tbody>
</table>

**Source:**
SSA AND RRB BENEFICIARY RECORD SYSTEMS.

**Limitations:**
In some cases, the code may not be the actual state of residence. (For example, if the beneficiary has a representative payee).

**Standard Alias:** BENE_BIRTH_DT

**Edit-Rules:**

YYDDD

**Source:**
SSA AND RRB BENEFICIARY RECORD SYSTEMS

**Standard Alias:** BENE_SEX_IDENT_CD
11. RACE

CHAR 1 30 30

THIS FIELD SPECIFIES THE RACE OF THE BENEFICIARY.

STANDARD ALIAS: BENE_RACE_CD

CODES:
0 = UNKNOWN
1 = WHITE
2 = BLACK
3 = OTHER

SOURCE:
SSA AND RRB BENEFICIARY RECORD SYSTEMS

LIMITATIONS:
RACE AS GIVEN BY BENEFICIARY TO SSA ON APPLICATION FOR SSN, NOT VERIFIED.

12. CURRENT REASON FOR ENTITLEMENT CODE

CHAR 1 31 31

THIS FIELD INDICATES THE REASON FOR THE BENEFICIARY’S CURRENT ENTITLEMENT TO MEDICARE BENEFITS.

CODES:
0 = OLD AGE AND SURVIVOR’S INSURANCE (OASI)
1 = DISABILITY INSURANCE BENEFITS (DIB)
2 = ESRD
3 = DIB AND ESRD

SOURCE:
ENROLLMENT DATA BASE
13. ORIGINAL REASON FOR ENTITLEMENT

CHAR 1 32 32

This field indicates the reason for the beneficiary’s original entitlement to Medicare benefits.

CODES:
0 = Old Age and Survivors Insurance (OASI)
1 = Disability Insurance Benefits (DIB)
2 = ESRD
3 = Both DIB and ESRD

SOURCE:
SSA and RRB Beneficiary Record Systems

14. RISI-PUDI CODE

CHAR 1 33 33

RISI indicates that the beneficiary’s entitlement to health insurance benefits is based on the fully or currently insured worker’s earnings and not on the beneficiary’s own earnings. PUDI indicates that the was previously disabled but not enough to qualify for HI on that basis.

CODES:
0 = Neither
1 = RISI
2 = PUDI
3 = RISI AND PUDI

SOURCE:
Uniform Bill HCFA Form 1450

15. MEDICARE STATUS CODE

CHAR 2 34 35

This field specifies the reason for the beneficiary’s entitlement.

STANDARD ALIAS: BENE_MDCR_STUS_CD
COMMON ALIAS: MSC

CODES:
10 = Aged without ESRD
11 = Aged with ESRD
20 = Disabled without ESRD
21 = Disabled with ESRD
31 = ESRD ONLY

SOURCE:
THIS FIELD IS CODED FROM AGE, ORIGINAL REASON
FOR ENTITLEMENT, CURRENT REASON FOR
ENTITLEMENT AND ESRD INDICATOR CONTAINED
IN THE ENROLLMENT DATA BASE AT THE
CENTRAL OFFICE AT THE DATE OF PROCESSING.

16. DATE OF SERVICE CHAR 5 36 40 THIS FIELD DENOTES THE DATE THE SERVICE WAS
INCURRED.

5 DIGITS

EDIT-RULES:
YYDDD

SOURCE:
UNIFORM BILL FORM 1450, ITEM 22

LIMITATIONS:
SUMMARY RECORDS SHOW ZEROES IN THIS FIELD.

17. DEBIT/CREDIT INDICATOR CHAR 1 41 41 (NOT USED--DOLLAR FIELDS ARE SIGNED. -CDS)

18. REIMBURSEMENT AMOUNT NUM 10 42 51 THE AMOUNT PAID BY MEDICARE. PASS-THRU,
INTERIM LUMP SUM ADJUSTMENTS, AND COST
STATEMENT SETTLEMENTS NOT INCLUDED.

7.2 DIGITS SIGNED

EDIT-RULES:
$$$$$$$.CC

SOURCE:
UNIFORM BILL HCFA FORM 1450, ITEM F UNDER 'FOR INTERMEDIARY USE ONLY'

LIMITATIONS:
THIS FIELD MAY BE ZEROES IF THE PATIENT’S
DEDUCTIBLE HAS NOT BEEN MET.
19. TOTAL CHARGES
NUM 10 52 61
THIS ITEM RECORDS THE TOTAL CHARGES, INCLUDING NON-COVERED CHARGES, FOR THE BENEFICIARY AS REPORTED BY THE PROVIDER.

7.2 DIGITS SIGNED

EDIT-RULES:
$$$$$$$.CC

SOURCE:
UNIFORM BILL HCFA FORM 1450, REVENUE CODE 001

**** ALL RECORDS OTHER THAN PAYMENT RECORDS AREA

**** ITEMS COMMON TO ALL RECORDS OTHER THAN PAYMENT RECORDS

20. PAYMENT/EDIT CODE
CHAR 1 62 62
THIS CODE INDICATES THE TYPE OF BILL SUBMITTED FOR PAYMENT OF BENEFITS.

CODES:
C = INPATIENT, SNF
D = OUTPATIENT
E = CHRISTIAN SCIENCE
F = HOME HEALTH
G = NON-PAYMENT BILLS
I = HOSPICE

SOURCE:
UNIFORM BILL HCFA FORM 1450, ITEM 4

21. TRANSACTION CODE
CHAR 1 63 63
THIS ITEM INDICATES THE TYPE OF INSTITUTIONAL PROVIDER.

CODES:
0 = CHRISTIAN SCIENCE SNF
1 = PSYCHIATRIC HOSPITAL
2 = TUBERCULOSIS HOSPITAL
3 = GENERAL CARE HOSPITAL
4 = REGULAR SNF
5 = HOME HEALTH AGENCY
22. QUERY CODE

CHAR 1 64 64

This field indicates the status of the bill received.

Codes:
0 = Credit Adjustment
1 = Interim
2 = Visits/HHA Benefits Exhausted
3 = Final Bill
4 = Discharge Notice
5 = Debit Adjustment
7 = Special Discharge Notice

Source:
Generated in Administrative Systems in HCFA Central Office

23. Medicare Provider Number

CHAR 6 65 70

This field specifies the institution that rendered services to a beneficiary. This is the unique number issued by the HCFA Regional Office to a provider of services upon initial certification for participation in the Medicare Program.

Codes:
SSTPPP Where:
SS = State of the Provider
   (SSA Standard State Codes)
T = Type of Provider
PPP = Provider Sequence Number
   - First two positions are the state code.
   Coding scheme:
   Refer to SSA_STD_STATE_TB
   - Positions 3 and sometimes 4 are used as a
CATEGORY IDENTIFIER. THE REMAINING POSITIONS ARE SERIAL NUMBERS. THE FOLLOWING BLOCKS OF NUMBERS ARE RESERVED FOR THE FACILITIES INDICATED:

0001-0899 SHORT-TERM (GENERAL AND SPECIALTY) HOSPITALS
0900-0999 MULTIPLE HOSPITAL COMPONENT IN A MEDICAL COMPLEX (NUMBERS RETIRED)
1000-1199 RESERVED FOR FUTURE USE
1200-1220 ALCOHOL/DRUG HOSPITALS (EXCLUDED FROM PPS–NUMBERS RETIRED)
1221-1299 MEDICAL ASSISTANCE FACILITIES (MONTANA PROJECT)
1300-1399 RURAL PRIMARY CARE HOSPITAL (RPCH)
1400-1499 RESERVED FOR FUTURE USE
1500-1799 HOSPICES
1800-1899 FEDERALLY-FUNDED COMPREHENSIVE HEALTH CENTERS
1900-1989 RESERVED FOR FUTURE USE
1990-1999 CHRISTIAN SCIENCE SANATORIA (HOSPITAL SERVICES)
2000-2299 LONG-TERM HOSPITALS (EXCLUDED FROM PPS)
2300-2499 CHRONIC RENAL DISEASE FACILITIES (HOSPITAL BASED)
2500-2899 NON-HOSPITAL RENAL DISEASE TREATMENT CENTERS
2900-2999 INDEPENDENT SPECIAL PURPOSE RENAL DIALYSIS FACILITY (1)
3000-3024 FORMERLY TUBERCULOSIS HOSPITALS (NUMBERS RETIRED)
3025-3099 REHABILITATION HOSPITALS (EXCLUDED FROM PPS)
3100-3299 RESERVED FOR FUTURE USE
3300-3399 CHILDREN’S HOSPITALS (EXCLUDED FROM PPS)
3400-3499 RESERVED FOR FUTURE USE
3500-3699 RENAL DISEASE TREATMENT CENTERS (HOSPITAL SATELLITES)
3700-3799 HOSPITAL BASED SPECIAL PURPOSE RENAL DIALYSIS FACILITY (1)
3800-3974 RURAL HEALTH CLINICS (FREE-STANDING)
3975-3999 RURAL HEALTH CLINICS (PROVIDER-BASED)
4000-4499 PSYCHIATRIC HOSPITALS (EXCLUDED
<table>
<thead>
<tr>
<th>Provider Numbers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4500-4599</td>
<td>Comprehensive Outpatient Rehabilitation Facilities (CORF)</td>
</tr>
<tr>
<td>4600-4999</td>
<td>Reserved for Future Use</td>
</tr>
<tr>
<td>5000-5999</td>
<td>Skilled Nursing Facilities</td>
</tr>
<tr>
<td>6000-6499</td>
<td>Reserved for Future Use (2) (3)</td>
</tr>
<tr>
<td>6500-6899</td>
<td>Outpatient Physical Therapy Services</td>
</tr>
<tr>
<td>6900-6989</td>
<td>Reserved for Future Use</td>
</tr>
<tr>
<td>6990-6999</td>
<td>Christian Science Sanatoria (Skilled Nursing Services)</td>
</tr>
<tr>
<td>7000-7299</td>
<td>Home Health Agencies (4)</td>
</tr>
<tr>
<td>7300-7399</td>
<td>Subunits of 'Nonprofit' and 'Proprietary' Home Health Agencies (5)</td>
</tr>
<tr>
<td>7400-7799</td>
<td>Continuation of 7000-7299 Series</td>
</tr>
<tr>
<td>7800-7999</td>
<td>Subunits of State and Local Governmental Home Health Agencies (5)</td>
</tr>
<tr>
<td>8000-8999</td>
<td>Reserved for Future Use</td>
</tr>
<tr>
<td>9000-9799</td>
<td>Reserved for Future Use</td>
</tr>
<tr>
<td>9800-9999</td>
<td>Reserved for Future Use</td>
</tr>
<tr>
<td>A001-A999</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>B001-B999</td>
<td>Nursing Facility (Expansion of A001-A999)</td>
</tr>
<tr>
<td>E001-E999</td>
<td>Nursing Facility</td>
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<td>F001-F999</td>
<td>Nursing Facility (Expansion of E001-E999)</td>
</tr>
<tr>
<td>G001-G999</td>
<td>Intermediate Care Facility for the Mentally Retarded</td>
</tr>
<tr>
<td>H001-H999</td>
<td>Intermediate Care Facility for the Mentally Retarded (Expansion of G001-G999)</td>
</tr>
<tr>
<td>P001-P999</td>
<td>Organ Procurement Organization</td>
</tr>
</tbody>
</table>

(1) These Facilities (SPRDFs) will be assigned the same provider number whenever they are recertified.

(2) This series of provider numbers has been released for use by the State of California (05) for Skilled Nursing Facilities only.

(3) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45) have been used in reducing acute care costs (RACC).
EXPERIMENTS.

(4) IN VIRGINIA (49), THE SERIES 7100-7299 HAS BEEN RESERVED FOR STATEWIDE SUBUNIT COMPONENTS OF THE VIRGINIA STATE HOME HEALTH AGENCIES.

(5) PARENT AGENCY MUST HAVE A NUMBER IN THE 7000-7299 OR 7400-7799 SERIES.

NOTE:
THERE IS A SPECIAL NUMBERING SYSTEM FOR UNITS OF HOSPITALS THAT ARE EXCLUDED FROM PROSPECTIVE PAYMENT SYSTEM (PPS) AND HOSPITALS WITH SNF SWING-BED DESIGNATION. AN ALPHA CHARACTER IN THE THIRD POSITION OF THE PROVIDER NUMBER IDENTIFIES THE TYPE OF UNIT OR SWING-BED DESIGNATION AS FOLLOWS:

S = PSYCHIATRIC UNIT (EXCLUDED FROM PPS)
T = REHABILITATION UNIT (EXCLUDED FROM PPS)
U = SHORT TERM/ACUTE CARE SWING-BED HOSPITAL
V = ALCOHOL DRUG UNIT (PRIOR TO 10/87 ONLY)
W = LONG TERM SNF SWING-BED HOSPITAL (EFF 3/91)
Y = REHAB HOSPITAL SWING-BED (EFF 9/92)
Z = RURAL PRIMARY CARE HOSPITALS (TO BE EFFECTIVE IN 1994)

SOURCE:
UNIFORM BILL 82, FORM HCFA-1450, ITEM 7 (MEDICARE PROVIDER NUMBER).

LIMITATIONS:
THE MEDPAR FILE CONTAINS ONLY INPATIENT HOSPITAL RECORDS. PROVIDER NUMBERS ARE AGAINST A FILE OF MEDICARE-CERTIFIED PROVIDERS BY THE INTERMEDIARY. HOWEVER, HOWEVER, THIS PROCESS IS NOT REPEATED WHEN THE MEDPAR FILE IS CONSTRUCTED.

24. DISTINCT PART CODE CHAR 1 71 71 THIS FIELD IS DERIVED FROM THE THIRD DIGIT OF THE PROVIDER NUMBER WHICH HAS BEEN RESET
TO ZERO. A VALUE OF 'S', 'T', OR 'U' INDICATES A PART OF A SHORT STAY HOSPITAL NOT COVERED BY PPS. A 'U' INDICATES A BED USED AS AN SNF BED.

CODES:
- BLANK = PROVIDER NUMBER NOT CHANGED
- S = PSYCHIATRIC UNIT
- T = REHABILITATION UNIT
- U = SWING-BED HOSPITAL DESIGNATION
- V = ALCOHOL/DRUG UNIT

SOURCE:
THIS IS A UNIQUE IDENTIFIER ISSUED BY THE HCFA REGIONAL OFFICE TO A PROVIDER OF SERVICE. THE CODE REPLACES THE THIRD DIGIT OF THE PROVIDER NUMBER.

LIMITATIONS:
EFFECTIVE WITH PROVIDER COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1987, THE ALCOHOL/DRUG UNITS ARE NO LONGER PPS-EXEMPT UNITS. A 'U' INDICATES A SNF.

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<thead>
<tr>
<th>25. NUMBER OF DIAGNOSIS CODES</th>
<th>NUM</th>
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<th>72</th>
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<tr>
<td>THIS FIELD INDICATES THE NUMBER OF DIAGNOSIS CODES PRESENT IN THE RECORD.</td>
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1 DIGIT

EDIT-RULES:
RANGE 0 THRU 5

SOURCE:
CALCULATED IN HCFA

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<th>**** DIAGNOSTIC CODES</th>
<th>GROUP</th>
<th>25</th>
<th>73</th>
<th>97</th>
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<tbody>
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<td>THESE FIELDS SPECIFY THE PRINCIPAL AND OTHER DIAGNOSIS CODES THAT ARE OBTAINED FROM THE PATIENT'S DISCHARGE BILL. PRINCIPAL IS DEFINED AS THE CONDITION ESTABLISHED, AFTER STUDY, TO BE CHIEFLY RESPONSIBLE FOR OCCASIONING THE ADMISSION OF THE PATIENT.</td>
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</table>
CODING IS BASED ON INTERNATIONAL CLASSIFICATION OF DISEASES 9TH REVISION, CLINICAL MODIFICATION (ICD-9-CM). PROVIDERS KEY THE ICD-9-CM CODE FROM THE BILLS AND REPORT THE INFORMATION TO HCFA AS PART OF THE CLAIMS TAPE RECORD. EACH CODE CAN BE UP TO FIVE CHARACTERS, LEFT JUSTIFIED. A MAXIMUM OF FIVE CODES IS CARRIED IN THE RECORD.

<table>
<thead>
<tr>
<th>Field</th>
<th>Type</th>
<th>Start</th>
<th>End</th>
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</thead>
<tbody>
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<td>26. Diagnosis Code</td>
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<td>77</td>
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<tr>
<td>Occurs: 5 Times</td>
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<tr>
<td>Source: Uniform Bill 82, Form HCFA-1450, Items 77 through 81</td>
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</tr>
<tr>
<td>Limitations: May contain invalid codes</td>
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<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field</th>
<th>Type</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Date of First Procedure</td>
<td>CHAR</td>
<td>5</td>
<td>98</td>
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<tr>
<td></td>
<td></td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>This is the date of the first surgical procedure.</td>
<td></td>
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<td></td>
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<tr>
<td>5 digits</td>
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<tr>
<td>Edit-rules: YYDDD</td>
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<tr>
<td>ZERO = date not submitted.</td>
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<tr>
<td>Source: Uniform Bill HCFA Form 1450, Item 84</td>
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<table>
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<th>Type</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Number of Procedure Codes</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>This field indicates the number of procedure codes present in the record.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 digit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edit-rules:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range: 0 to 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CALCULATED IN HCFA

**** PROCEDURE CODES

GROUP 12 104 115 THESE CODES INDICATE WHICH SURGICAL PROCEDURES, IF ANY, WERE PERFORMED DURING THE STAY.

CODING IS BASED ON ICD-9-CM MANUAL, VOLUME 3. PROVIDERS KEY THE ICD-9-CM CODE AND REPORT THE INFORMATION TO HCFA AS PART OF THE CLAIMS TAPE RECORD. EACH CODE CAN BE UP TO FOUR CHARACTERS, LEFT JUSTIFIED. A MAXIMUM OF THREE CODES ARE CARRIED IN THE RECORD. THIS FIELD IS BLANK IF NO CODE IS SUBMITTED.

29. PROCEDURE CODE CHAR 4 104 107 OCCURS: 3 TIMES

SOURCE: UNIFORM BILL HCFA-1450, ITEMS 84 THROUGH 86

LIMITATIONS: MAY CONTAIN INVALID CODE

30. DATE OF SECOND PROCEDURE CHAR 5 116 120 THIS IS THE DATE OF THE SECOND SURGICAL PROCEDURE PERFORMED.

5 DIGITS

EDIT-RULES: YYDDD
ZEROS = DATE NOT SUBMITTED
UNIFORM BILL HCFA FORM 1450, ITEM 85

31. DATE OF THIRD PROCEDURE CHAR 5 121 125 THIS IS THE DATE OF THE THIRD SURGICAL PROCEDURE PERFORMED.

5 DIGITS

EDIT-RULES: YYDDD
ZEROS = DATE NOT SUBMITTED
SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 86
32. APPROVAL DATE
CHAR 5 126 130
THE APPROVAL DATE SHOWS THE DATE THE BILL WAS APPROVED BY THE INTERMEDIARY.

5 DIGITS
EDIT-RULES:
YYDDD
SOURCE:
UNIFORM BILL HCFA FORM 1450, IN 'FOR INTERMEDIARY USE ONLY', ITEM K

LIMITATIONS:
THIS FIELD IS NOT ALWAYS PRESENT. ALSO, THE SUMMARY RECORD WILL EXHIBIT ZEROES IN THIS FIELD.

**** INPATIENT SNF CHRISTIAN SCIENCE BILLS AND NO PAYMENT BILLS

33. PPS INDICATOR
CHAR 1 131 131
THIS FIELD SPECIFIES WHETHER A HOSPITAL IS BEING PAID UNDER THE PROSPECTIVE PAYMENT SYSTEM (PPS).

CODES:
1 = YES
0 = NO

SOURCE:
The PPS INDICATOR IS SET AT THE CENTRAL OFFICE AND IS CODED BY THE INTERMEDIARY. A CODE OTHER THAN '65' IN THE UNIBILL CONDITION CODE FIELD INDICATES THAT THIS IS A PPS PROVIDER.

LIMITATIONS:

34. DIAGNOSIS RELATED GROUP (DRG) CODE
NUM 3 132 134
EACH DRG REPRESENTS BROAD CLINICAL CATEGORIES THAT ARE BASED ON BODY SYSTEM INVOLVEMENT AND
DISEASE ETIOLOGY. EACH CATEGORY IS SIMILAR IN ITS USE OF DIAGNOSTIC RESOURCES AND IS USING SPECIFIC GUIDELINES. EACH CATEGORY MUST HAVE BEEN CLINICALLY CONSISTENT, HAD A SUFFICIENT NUMBER OF PATIENTS, AND COVERED THE COMPLETE RANGE OF DIAGNOSES REPRESENTED IN THE ICD-9-CM WITHOUT OVERLAP. THE CATEGORIES WERE DEVELOPED BY A YALE UNIVERSITY RESEARCH TEAM AND REVISED BY HEALTH SERVICES INTERNATIONAL, INC.

3 DIGITS

EDIT-RULES:
NUMERIC

SOURCE:
ADDED TO THE RECORD BY THE INTERMEDIARY’S GROUPER SOFTWARE WHICH TRANSLATES VARIABLES SUCH AS AGE, SEX, DIAGNOSIS AND SURGICAL CODES INTO THE SINGLE APPLICABLE DRG.

THE GROUPER SOFTWARE IS UPDATED PERIODICALLY AS SHOWN BELOW:
- VERSION 2.0 (EFF 1/1/83 - 4/30/86)
- VERSION 3.0 (EFF 5/1/86 - 9/30/86)
- VERSION 4.0 (EFF 10/1/86 - 9/30/87)
- VERSION 5.0 (EFF 10/1/87 - 9/30/88)
- VERSION 6.0 (EFF 10/1/88 - 9/30/89)
- VERSION 7.0 (EFF 10/1/89 - 9/30/90)

LIMITATIONS:
DRG 467 AND DRG 470 ARE CATEGORIES WHICH COULD NOT BE ACCURATELY CLASSIFIED INTO VALID DRG’S.

35. DISCHARGE DESTINATION NUM 2 135 136 THIS FIELD SPECIFIES THE DESTINATION OF THE PATIENT UPON DISCHARGE FROM THE HOSPITAL.

2 DIGITS

CODES:
01 = TO HOME, SELF-CARE
02 = TO SHORT-TERM HOSPITAL
03 = TO SNF
04 = TO ICF
05 = TO OTHER TYPE FACILITY
06 = TO HOME HEALTH SERVICE CARE
07 = LEFT AGAINST MEDICAL ADVICE
08 = TO HOME, HOME IV THERAPY PROVIDER
20 = DIED
30 = STILL A PATIENT OR EXPECTED TO RETURN
     FOR OUTPATIENT SERVICES

SOURCE:
UNIFORM BILL 82, FORM HCFA-1450, ITEM 21

LIMITATIONS:
THIS FIELD HAS NOT BEEN VALIDATED.  THERE IS
SOME QUESTION OF ITS RELIABILITY.

36. MEDICAL RECORD NUMBER  CHAR  17 137 153  THIS NUMBER IS ASSIGNED BY THE PROVIDER TO
PATIENT RECORDS.

SOURCE:
UNIFORM BILL HCFA FORM 1450, ITEM 3

LIMITATIONS:
THIS IS AN UNEDITED ELEMENT.

37. DATE OF ADMISSION  CHAR  5 154 158  THIS FIELD CONTAINS THE DATE THE BENEFICIARY
WAS ADMITTED FOR INPATIENT CARE TO THE
INSTITUTION.

5 DIGITS

EDIT-RULES:
YYDDDD

SOURCE:
UNIFORM BILL HCFA FORM 1450, ITEM 15

LIMITATIONS:
MODIFICATION MAY PLACE THE DATE OUTSIDE THE
FILE YEAR.
<table>
<thead>
<tr>
<th>Field</th>
<th>Type</th>
<th>Start</th>
<th>End</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>38. FROM DATE</td>
<td>CHAR</td>
<td>5</td>
<td>159 163</td>
<td>BEGINNING DATE OF STAY OR SERVICE.</td>
</tr>
<tr>
<td>39. LENGTH OF STAY</td>
<td>NUM</td>
<td>4</td>
<td>164 167</td>
<td>THIS FIELD GIVES THE TOTAL LENGTH OF A PATIENT’S HOSPITAL STAY FROM THE DATE OF ADMISSION TO THE DATE OF DISCHARGE.</td>
</tr>
<tr>
<td>40. TOTAL INPATIENT DAYS</td>
<td>NUM</td>
<td>4</td>
<td>168 171</td>
<td>NUMBER OF DAYS FROM ADMISSION TO ‘THROUGH DATE’ ON THIS BILL.</td>
</tr>
</tbody>
</table>
41. TOTAL NUMBER OF INPATIENT COVERED DAYS  
 NUM  4  172  175  3 DIGITS SIGNED  
 SOURCE:  
 MEDICARE UTILIZATION RECORDS  
 LIMITATIONS:  
 NOT AVAILABLE FOR UTILIZATION PRIOR TO 1982  
  
42. DISPROPORTIONATE SHARE RATE  
 NUM  9  176  184  RATE REFLECTING INDIGENT POPULATION SERVED. THIS FACTOR IS INCLUDED IN REIMBURSEMENT AMOUNT.  
 6.2 DIGITS SIGNED  
 EDIT-RULES:  
 UNIBILL VALUE CODE 18 AMOUNT FROM THE INTERMEDIARY PRICER REPORT  
 SOURCE:  
 PRICER  
 LIMITATIONS:  
 NOT SHOWN ON MOST RECORDS  
  
43. INDIRECT MEDICAL EDUCATION (IME) AMOUNT  
 NUM  9  185  193  THIS FIELD SPECIFIES THE ADDITIONAL AMOUNT PAID TO TEACHING HOSPITALS FOR IME.  
 6.2 DIGITS SIGNED  
 EDIT-RULES:  
 UNIBILL VALUE CODE 19 AMOUNT FROM THE PRICER REPORT.  
 SOURCE:  
 PRICER  
 LIMITATIONS:  
 CALCULATED FROM THE PRICE REPORT  
  
44. ORGAN ACQUISITION CHARGE  
 NUM  9  194  202  ACTUAL COST TO ACQUIRE AN ORGAN. NOT INCLUDED IN REIMBURSEMENT AMOUNT. SINCE THIS COST CAN VARY GREATLY WITH EACH INDIVIDUAL CASE, PAYMENT IS MADE TO EACH PROVIDER BASED ON THE
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45. PASS-THRU PER DIEM</td>
<td>NUM 9 203 211  The pass-thru per diem amount consists of the pass-thru per diem rate times the number of Medicare days billed. The pass-thru per diem rate consists of the established reimbursable costs for the current year divided by the estimated Medicare days for the current year. It is not included in the reimbursement amount; these amounts are a part of the interim lump sum adjustments made periodically to the provider.</td>
</tr>
<tr>
<td>46. COINSURANCE AMOUNT</td>
<td>NUM 9 212 220  This amount, reported as coinsurance, is to be paid by the beneficiary.</td>
</tr>
</tbody>
</table>
47. PRIMARY PAYER CODE             CHAR  1 221 221  THIS FIELD INDICATES WHO IS PRIMARILY RESPONSIBLE FOR PAYMENT.

CODES:
A = WORKING AGED BENE/SPOUSE WITH EMPLOYER GROUP HEALTH PLAN (EGHP)
B = END STAGE RENAL DISEASE (ESRD) BENEFICIARY IN THE 12 MONTH COORDINATION PERIOD WITH AN EMPLOYER GROUP HEALTH PLAN
C = CONDITIONAL PAYMENT BY MEDICARE; FUTURE REIMBURSEMENT EXPECTED
D = AUTOMOBILE NO-FAULT OR ANY LIABILITY INSURANCE
E = WORKERS’ COMPENSATION
F = PUBLIC HEALTH SERVICE OR OTHER FEDERAL AGENCY (OTHER THAN DEPT. OF VETERANS AFFAIRS)
G = WORKING DISABLED
H = BLACK LUNG
I = DEPT. OF VETERANS AFFAIRS
1 = POTENTIAL WORKERS’ COMPENSATION
2 = POTENTIAL BLACK LUNG
3 = POTENTIAL DEPT. OF VETERANS AFFAIRS

*EFFECTIVE 12/90 FOR CWFB CLAIMS; 10/93 FOR INSTITUTIONAL CLAIMS

M = OVERRIDE CODE: EGHP SERVICES INVOLVED
N = OVERRIDE CODE: NON-EGHP SERVICES INVOLVED
X = OVERRIDE CODE MSP COST AVOIDED
BLANK = MEDICARE IS PRIMARY PAYER

***PRIOR TO 12/90***

Y = OTHER SECONDARY PAYER INVESTIGATION SHOWS MEDICARE AS PRIMARY PAYER
Z = MEDICARE IS PRIMARY PAYER
48. PRIMARY PAYOR AMOUNT  NUM  9 222 230  THE AMOUNT OF MEDICARE EXPENSES PAID BY PRIMARY PAYOR.

6.2 DIGITS SIGNED

EDIT-RULES:
$$$$$.CC
ZERO FOR CODES C AND Z.
NINES FILLED ON OVERFLOW.

SOURCE:
UNIFORM BILL HCFA FORM 1450, ITEM 64

49. PASS-THRU SOURCE CODE BILL  CHAR  1 231 231  A UNIQUE CODE INDICATING WHERE PASS-THRU AMOUNT ORIGINATED.

CODES:
H = PASS-THRU AMOUNT FROM COST REPORT
B = PASS-THRU AMOUNT FROM BILL
X = NO PASS-THRU AMOUNT

SOURCE:
BUREAU OF DATA MANAGEMENT AND STRATEGY, HCFA

**** OUTPATIENT  GROUP  32 131 162  REDEFINITION OF: IP-SNF-CS-AREA

50. NUMBER OF HCPCS CODES  NUM  1 131 131  THIS FIELD SHOWS THE NUMBER OF HCPCS SURGICAL PROCEDURES PERFORMED.

1 DIGIT
SOURCE:
CALCULATED IN HCFA

**** HCPCS CODES  GROUP  15 132 146  THIS FIELD CONTAINS UP TO THREE HCPCS CODES.

51. HCFA COMMON PROCEDURE CODING SYSTEM CODE  CHAR  5 132 136  THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS) IS A COLLECTION OF CODES THAT REPRESENT PROCEDURES,
SUPPLIES, PRODUCTS AND SERVICES WHICH MAY BE PROVIDED TO MEDICARE BENEFICIARIES AND TO INDIVIDUALS ENROLLED IN PRIVATE HEALTH INSURANCE PROGRAMS. THE CODES ARE DIVIDED INTO THREE LEVELS, OR GROUPS, AS DESCRIBED BELOW:

LEVEL I
CODES COPYRIGHTED BY THE AMERICAN MEDICAL ASSOCIATION’S CURRENT PROCEDURAL TERMINOLOGY, FOURTH EDITION (CPT-4). THESE ARE 5 POSITION NUMERIC CODES REPRESENTING PHYSICIAN AND NONPHYSICIAN SERVICES.

LEVEL II
CODES APPROVED AND MAINTAINED JOINTLY BY THE ALPHA-NUMERIC WORKGROUP (CONSISTING OF HCFA, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AND THE BLUE CROSS AND BLUE SHIELD ASSOCIATION). THESE ARE 5 POSITION ALPHA-NUMERIC CODES REPRESENTING PHYSICIAN AND NONPHYSICIAN SERVICES THAT ARE NOT REPRESENTED IN THE LEVEL I CODES.

LEVEL III
CODES DEVELOPED BY MEDICARE CARRIERS FOR USE AT THE LOCAL (CARRIER) LEVEL. THESE ARE 5 POSITION ALPHA-NUMERIC CODES IN THE W, X, Y OR Z SERIES REPRESENTING PHYSICIAN PHYSICIAN AND NONPHYSICIAN SERVICES THAT ARE NOT REPRESENTED IN THE LEVEL I OR LEVEL II CODES.

OCCURS: 3 TIMES

STANDARD ALIAS: HCPCS_CD

SOURCE:
UNIFORM BILL HCFA FORM 1450,
ITEM 50 - DESCRIPTION
**LIMITATIONS:**
THESE CODES ARE USED FOR OUTPATIENT SERVICES ONLY.

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Description</th>
<th>Type</th>
<th>Start</th>
<th>End</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>52. DATE OF FIRST HCPCS PROCEDURE</td>
<td>THIS DENOTES THE DATE OF THE FIRST HCPCS PROCEDURE.</td>
<td>CHAR</td>
<td>5</td>
<td>147</td>
<td>151</td>
</tr>
<tr>
<td></td>
<td>5 DIGITS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td>YYDDD ZEROS = DATE NOT SUBMITTED</td>
</tr>
<tr>
<td></td>
<td>SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 84</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53. DATE OF SECOND HCPCS PROCEDURE</td>
<td>THIS FIELD DENOTES THE DATE OF THE SECOND HCPCS PROCEDURE.</td>
<td>CHAR</td>
<td>5</td>
<td>152</td>
<td>156</td>
</tr>
<tr>
<td></td>
<td>5 DIGITS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td>YYDDD ZEROS = DATE NOT SUBMITTED</td>
</tr>
<tr>
<td></td>
<td>SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 85</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54. DATE OF THIRD HCPCS PROCEDURE</td>
<td>THIS FIELD DENOTES THE DATE OF THE THIRD HCPCS PROCEDURE.</td>
<td>CHAR</td>
<td>5</td>
<td>157</td>
<td>161</td>
</tr>
<tr>
<td></td>
<td>5 DIGITS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td>YYDDD ZEROS = DATE NOT SUBMITTED</td>
</tr>
<tr>
<td></td>
<td>SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 86</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55. INTERVENING CARE INDICATOR</td>
<td>THIS ONE DIGIT FIELD SHOWS WHETHER THE BENEFICIARY RECEIVED ANY INTERVENING CARE.</td>
<td>CHAR</td>
<td>1</td>
<td>162</td>
<td>162</td>
</tr>
</tbody>
</table>


CODES:
N = NO INTERVENING CARE
Y = YES, BENEFICIARY RECEIVED INTERVENING CARE

SOURCE:
SET BY BILL PROCESSING
(MISSING FOR SOME OUTPATIENT RECORDS. -CDS)

**** HOME HEALTH AGENCY GROUP 19 131 149 REDEFINITION OF: IP-SNF-CS-AREA

56. PATIENT STATUS CHAR 1 131 131 A CODE DESCRIBING THE CURRENT STATUS OF THE PATIENT REGARDING HOME HEALTH AGENCY SERVICES

CODES:
A = DISCHARGE
B = DIED
C = STILL PATIENT
D = VISITS EXHAUSTED (HHA ONLY)

SOURCE:
UNIFORM BILL HCFA FORM 1450, ITEM 21

57. SERVICE FROM DATE CHAR 5 132 136 A FIELD USED TO SHOW THE BEGINNING DATE OF THE SERVICE.

5 DIGITS

CODES:
YYDDD

SOURCE:
UNIFORM BILL HCFA FORM 1450, ITEM 22

58. TOTAL HHA VISITS NUM 4 137 140 THIS FIELD REFLECTS THE TOTAL NUMBER OF VISITS PROVIDED BY THE HOME HEALTH AGENCY.

3 DIGITS SIGNED

SOURCE:
UNIFORM BILL HCFA FORM 1450, ACCUMULATED UNITS
OF SERVICES, REVENUE CODES 42X - 44X, 47X, AND 55X - 58X

59. TOTAL HHA VISIT CHARGES  NUM  9  141  149  THIS FIELD REFLECTS THE TOTAL OF ALL HOME HEALTH AGENCY VISIT CHARGES INCURRED ON THIS ACCOUNT.

   6.2 DIGITS SIGNED

   EDIT-RULES:
   $$$$$$.CC

   SOURCE:
   UNIFORM BILL HCFA FORM 1450, ACCUMULATED UNITS OF CHARGES

4****  HOSPICE  GROUP  21  131  151  REDEFINITION OF: IP-SNF-CS-AREA

60. HOSPICE DISCHARGE DESTINATION  CHAR  2  131  132  CODE INDICATES DESTINATION UPON DISCHARGE FROM FACILITY

   2 DIGITS

   CODES:
   01 = TO HOME, SELF-CARE
   02 = TO SHORT-TERM HOSPITAL
   03 = TO SNF
   04 = TO ICF
   05 = TO OTHER TYPE OF FACILITY
   06 = TO HOME HEALTH SERVICE CARE
   07 = LEFT AGAINST MEDICAL ADVICE
   30 = STILL PATIENT
   40 = DIED AT HOME
   41 = DIED IN A MEDICAL INSTITUTION
   42 = PLACE OF DEATH UNKNOWN

   SOURCE:
   UNIFORM BILL HCFA FORM 1450, ITEM 21

   LIMITATIONS:
   THIS FIELD HAS NOT BEEN VALIDATED. THERE IS SOME QUESTION OF ITS RELIABILITY.
<table>
<thead>
<tr>
<th>Field</th>
<th>Type</th>
<th>Codes</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>61. HOSPICE PERIOD NUMBER</td>
<td>NUM 1 133 133</td>
<td>1 DIGIT</td>
<td>AN INDIVIDUAL MAY ELECT TO RECEIVE MEDICARE COVERAGE OF THREE ELECTIVE PERIODS OF HOSPICE CARE. THE PERIODS CONSIST OF TWO 90-DAY PERIODS AND ONE 30-DAY PERIOD. THE TWO 90-DAY PERIODS MUST BE USED BEFORE THE 30-DAY PERIOD.</td>
<td>CODES: 1 = PERIOD 1, 2 = PERIOD 2, 3 = PERIOD 3</td>
</tr>
<tr>
<td>62. SERVICE FROM DATE</td>
<td>CHAR 5 134 138</td>
<td>5 DIGITS</td>
<td>DATE THAT BEGINS THE STAY OR SERVICE</td>
<td>EDIT-RULES: YYDDD</td>
</tr>
<tr>
<td>63. HOSPICE START DATE</td>
<td>CHAR 5 139 143</td>
<td>5 DIGITS</td>
<td>DATE OF ADMISSION TO HOSPICE</td>
<td>EDIT-RULES: YYDDD</td>
</tr>
<tr>
<td>64. INPATIENT DAYS OF CARE</td>
<td>NUM 4 144 147</td>
<td>3 DIGITS SIGNED</td>
<td>TOTAL INPATIENT DAYS OF CARE.</td>
<td>EDIT-RULES:</td>
</tr>
</tbody>
</table>
001 = ZERO DAYS OF CARE

SOURCE:
UNIFORM BILL HCFA FORM 1450, ITEM 22 MINUS ITEM 15

65. LENGTH OF BILLING PERIOD  NUM     4  148  151 DATE OF ADMISSION THROUGH DATE OF LAST SERVICE.
                                      NOT COMPUTED FOR INTERIM BILLS.
                                      3 DIGITS SIGNED

EDIT-RULES:
THREE DIGITS
IF ZERO, VALUE SET TO ONE DAY

SOURCE:
UNIFORM BILL HCFA FORM 1450, ITEM 22

**** PAYMENT RECORD DATA  GROUP     26  62  87 REDEFINITION OF: MADRS-NOT-PMT-REC-AREA

66. ENTRY CODE  CHAR     1  62  62 INDICATES THE TYPE OF PAYMENT RECORD SUBMITTED

CODES:
1 = ORIGINAL DEBIT
2 = SUPPLEMENTAL DEBIT
3 = FULL CREDIT
4 = PARTIAL CREDIT
5 = REPLACEMENT DEBIT
6 = PARTIAL DEBIT

SOURCE:
THIS FIELD IS CODED BY THE CARRIER.

67. ENTRY RE-CODE  CHAR     1  63  63 CODE FURTHER DEFINING ENTRY CODES

CODES:
1,3,5,7,9 = INITIALLY SUBMITTED, ACCEPTED RECORDS
2,4,6,8 = RESUBMITTED, ACCEPTED RECORDS
A,C,E,G = INITIALLY SUBMITTED, REJECTED RECORDS
B,D,F,H = RESUBMITTED, REJECTED RECORDS
X = ACKNOWLEDGES AN A REJECT
68. CARRIER NUMBER

CHAR  5  64  68
HCFA-ASSIGNED IDENTIFICATION NUMBER

CODES:
NNNNN = IDENTIFICATION NUMBER
SUMRY = OFFICE VISITS WHICH ARE SUMMARIZED
SOURCE:
MEDICARE PAYMENT RECORDS

69. PLACE OF SERVICE

CHAR  1  69  69
THIS FIELD REFLECTS THE PLACE OF SERVICE.
PLACE OF SERVICE IS DETERMINED BY THE LARGEST
ALLOWED CHARGE REPORTED ON THE BILL.

CODES:
1 = OFFICE
2 = HOME
3 = INPATIENT HOSPITAL
4 = ECF/NURSING HOME
5 = OUTPATIENT HOSPITAL
6 = INDEPENDENT LABORATORIES
7 = OTHER
8 = INDEPENDENT KIDNEY DISEASE TREATMENT
    CENTER
9 = AMBULATORY SURGERY CENTER
H = HOSPICE

SOURCE:
MEDICARE PAYMENT RECORDS

70. TYPE OF SERVICE

CHAR  1  70  70
THIS CODE DELINEATES THE TYPE OF SERVICE
ADMINISTERED. TYPE OF SERVICE IS DETERMINED
BY THE LARGEST ALLOWED CHARGE REPORTED ON
THE BILL.

CODES:
0 = WHOLE BLOOD OR PACKED RED CELLS
1 = MEDICAL CARE
2 = SURGERY
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>CONSULTATION</td>
</tr>
<tr>
<td>4</td>
<td>DIAGNOSTIC X-RAY</td>
</tr>
<tr>
<td>5</td>
<td>DIAGNOSTIC LABORATORY</td>
</tr>
<tr>
<td>6</td>
<td>RADIATION THERAPY</td>
</tr>
<tr>
<td>7</td>
<td>ANESTHESIA</td>
</tr>
<tr>
<td>8</td>
<td>ASSISTANCE AT SURGERY</td>
</tr>
<tr>
<td>9</td>
<td>OTHER MEDICAL SERVICES</td>
</tr>
<tr>
<td>A</td>
<td>PURCHASE/RENTAL DURABLE MEDICAL EQUIPMENT (DME)</td>
</tr>
<tr>
<td>F</td>
<td>AMBULATORY SURGICAL CENTER (FACILITY USAGE)</td>
</tr>
<tr>
<td>L</td>
<td>RENAL SUPPLIES IN THE HOME</td>
</tr>
<tr>
<td>M</td>
<td>ALTERNATIVE PAYMENT METHOD FOR MAINTENANCE</td>
</tr>
<tr>
<td></td>
<td>DIALYSIS</td>
</tr>
<tr>
<td>N</td>
<td>KIDNEY DONOR</td>
</tr>
<tr>
<td>V</td>
<td>PNEUMOCOCCAL VACCINE</td>
</tr>
<tr>
<td>W</td>
<td>PHYSICAL THERAPY</td>
</tr>
<tr>
<td>Y</td>
<td>SURGICAL SECOND OPINION</td>
</tr>
<tr>
<td>Z</td>
<td>SURGICAL THIRD OPINION</td>
</tr>
</tbody>
</table>

**SOURCE:**

MEDICARE PAYMENT RECORDS

---

**71. PHYSICIAN SPECIALTY OR SUPPLIER SPECIALTY CODE**

<table>
<thead>
<tr>
<th>CHAR</th>
<th>CODE INDICATING THE PHYSICIAN’S OR SUPPLIER’S MAJOR SPECIALTY.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>71  72</td>
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</table>

**CODES:**

**PRIOR TO 3/92**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>GENERAL PRACTICE</td>
</tr>
<tr>
<td>02</td>
<td>GENERAL SURGERY</td>
</tr>
<tr>
<td>03</td>
<td>ALLERGY (REVISED 10/91 TO MEAN ALLERGY/IMMUNOLOGY)</td>
</tr>
<tr>
<td>04</td>
<td>OTOLARYNGOLOGY (REVISED 10/91 TO MEAN OTOLARYNGOLOGY)</td>
</tr>
<tr>
<td>05</td>
<td>ANESTHESIOLOGY</td>
</tr>
<tr>
<td>06</td>
<td>CARDIOVASCULAR DISEASE (REVISED 10/91 TO MEAN CARDIOLOGY)</td>
</tr>
<tr>
<td>07</td>
<td>DERMATOLOGY</td>
</tr>
<tr>
<td>08</td>
<td>FAMILY PRACTICE</td>
</tr>
<tr>
<td>09</td>
<td>GYNECOLOGY--OSTEOPATHS ONLY (DELETED 10/91; CHANGED TO ‘16’)</td>
</tr>
<tr>
<td>10</td>
<td>GASTROENTEROLOGY</td>
</tr>
</tbody>
</table>
11 = INTERNAL MEDICINE
12 = MANIPULATIVE THERAPY (OSTEOPATHS ONLY)
    (REVISED 10/91 TO MEAN OSTEOPATHIC
     MANIPULATIVE THERAPY)
13 = NEUROLOGY
14 = NEUROLOGICAL SURGERY (REVISED 10/91 TO
    MEAN NEUROSURGERY)
15 = OBSTETRICS--OSTEOPATHS ONLY (DELETED
    10/91; CHANGED TO ‘16’)
16 = OB-GYNECOLOGY
17 = OPHTHALMOLOGY, OTOLOGY, LARYNGOLOGY
    RHINOLOGY--OSTEOPATHS ONLY (DELETED
    10/91; CHANGED TO ‘18’ IF PHYSICIANS
    PRACTICE IS MORE THAN 50% OPHTHALMOLOGY
    OR TO ‘04’ IF PHYSICIAN’S PRACTICE IS
    MORE THAN 50% OTOLARYNGOLOGY. IF
    PRACTICE IS 50/50, CHOOSE SPECIALTY
    WITH GREATER ALLOWED CHARGES.
18 = OPHTHALMOLOGY
19 = ORAL SURGERY (DENTISTS ONLY)
20 = ORTHOPEDIC SURGERY
21 = PATHOLOGIC ANATOMY, CLINICAL PATHOLOGY--
    OSTEOPATHS ONLY (DELETED 10/91;
    CHANGED TO ‘22’)
22 = PATHOLOGY
23 = PERIPHERAL VASCULAR DISEASE OR SURGERY
    (DELETED 10/91; CHANGED TO ‘76’)
24 = PLASTIC SURGERY (REVISED TO MEAN
    PLASTIC AND RECONSTRUCTIVE SURGERY).
25 = PHYSICAL MEDICINE AND REHABILITATION
26 = PSYCHIATRY
27 = PSYCHIATRY, NEUROLOGY (OSTEOPATHS ONLY)
    (DELETED 10/91; CHANGED TO ‘86’)
28 = PROCTOLOGY (REVISED 10/91 TO MEAN
    COLORECTAL SURGERY).
29 = PULMONARY DISEASE
30 = RADIOLOGY (REVISED 10/91 TO MEAN DIAG-
    NOSTIC RADIOLOGY)
31 = ROENTGENOLOGY, RADIOLOGY (OSTEOPATHS)
    (DELETED 10/91; CHANGED TO ‘30’)
32 = RADIATION THERAPY--OSTEOPATHS (DELETED
    10/91; CHANGED TO ‘92’)
33 = THORACIC SURGERY  
34 = UROLOGY  
35 = CHIROPRACTOR, LICENSED (REVISED 10/91 TO MEAN CHIROPRACTIC)  
36 = NUCLEAR MEDICINE  
37 = PEDIATRICS (REVISED 10/91 TO MEAN PEDIATRIC MEDICINE)  
38 = GERIATRICS (REVISED 10/91 TO MEAN GERIATRIC MEDICINE)  
39 = NEPHROLOGY  
40 = HAND SURGERY  
41 = OPTOMETRIST - SERVICES RELATED TO CONDITION OF APHAKIA (REVISED 10/91 TO MEAN OPTOMETRIST)  
42 = CERTIFIED NURSE MIDWIFE (ADDED 7/88)  
43 = CERTIFIED REGISTERED NURSE ANESTHETIST (REVISED 10/91 TO MEAN CRNA, ANESTHESIA ASSISTANT)  
44 = INFECTIOUS DISEASE  
46 = ENDOCRINOLOGY (ADDED 10/91)  
48 = PODIATRY - SURGERY CHIROPODY (REVISED 10/91 TO MEAN PODIATRY)  
49 = MISCELLANEOUS (INC ASCS)  
51 = MEDICAL SUPPLY COMPANY WITH C.O. CERTIFICATION (CERTIFIED ORTHOTIST - CERTIFIED BY AMERICAN BOARD FOR CERTIFICATION IN PROSThetics AND ORTHOTICS.  
52 = MEDICAL SUPPLY COMPANY WITH C.P. CERTIFICATION (CERTIFIED PROSTHETIST - CERTIFIED BY AMERICAN BOARD FOR CERTIFICATION IN PROSThetics AND ORTHOTICS).  
53 = MEDICAL SUPPLY COMPANY WITH C.P.O. CERTIFICATION (CERTIFIED PROSTHETICS - ORTHOTIST - CERTIFIED BY AMERICAN BOARD FOR CERTIFICATION IN PROSThetics AND ORTHOTICS).  
54 = MEDICAL SUPPLY COMPANY NOT INCLUDED IN 51, 52, OR 53.  
55 = INDIVIDUAL CERTIFIED ORTHOTIST  
56 = INDIVIDUAL CERTIFIED PROSTHETIST  
57 = INDIVIDUAL CERTIFIED PROSTHETICS -
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>58</td>
<td>INDIVIDUALS NOT INCLUDED IN 55, 56 OR 57</td>
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<tr>
<td>59</td>
<td>AMBULANCE SERVICE SUPPLIER (E.G. PRIVATE AMBULANCE COMPANIES, FUNERAL HOMES, ETC.)</td>
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<tr>
<td>60</td>
<td>PUBLIC HEALTH OR WELFARE AGENCIES (FEDERAL, STATE, AND LOCAL)</td>
</tr>
<tr>
<td>61</td>
<td>VOLUNTARY HEALTH OR CHARITABLE AGENCIES (E.G. NATIONAL CANCER SOCIETY, NATIONAL HEART ASSOCIATION, CATHOLIC CHARITIES)</td>
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<tr>
<td>62</td>
<td>PSYCHOLOGIST--BILLING INDEPENDENTLY</td>
</tr>
<tr>
<td>63</td>
<td>PORTABLE X-RAY SUPPLIER--BILLING INDEPENDENTLY (REVISED 10/91 TO MEAN PORTABLE X-RAY SUPPLIER)</td>
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<tr>
<td>64</td>
<td>AUDIOLOGIST (BILLING INDEPENDENTLY)</td>
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<tr>
<td>65</td>
<td>PHYSICAL THERAPIST (INDEPENDENT PRACTICE)</td>
</tr>
<tr>
<td>66</td>
<td>RHEUMATOLOGY (ADDED 10/91)</td>
</tr>
<tr>
<td>67</td>
<td>OCCUPATIONAL THERAPIST--INDEPENDENT PRACTICE</td>
</tr>
<tr>
<td>68</td>
<td>CLINICAL PSYCHOLOGIST</td>
</tr>
<tr>
<td>69</td>
<td>INDEPENDENT LABORATORY--BILLING INDEPENDENTLY (REVISED 10/91 TO MEAN INDEPENDENT CLINICAL LABORATORY--BILLING INDEPENDENTLY)</td>
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<tr>
<td>70</td>
<td>CLINIC OR OTHER GROUP PRACTICE, EXCEPT GROUP PRACTICE PREPAYMENT PLAN (GPPP)</td>
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<tr>
<td>71</td>
<td>GROUP PRACTICE PREPAYMENT PLAN -- DANGNOSTIC X-RAY</td>
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<td>72</td>
<td>GROUP PRACTICE PREPAYMENT PLAN -- DANGNOSTIC LABORATORY</td>
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<td>73</td>
<td>GROUP PRACTICE PREPAYMENT PLAN -- PHYSIOTHERAPY</td>
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<td>74</td>
<td>GROUP PRACTICE PREPAYMENT PLAN -- OCCUPATIONAL THERAPY</td>
</tr>
<tr>
<td>75</td>
<td>GROUP PRACTICE PREPAYMENT PLAN -- OTHER MEDICAL CARE</td>
</tr>
<tr>
<td>76</td>
<td>PERIPHERAL VASCULAR DISEASE (ADDED 10/91)</td>
</tr>
<tr>
<td>77</td>
<td>VASCULAR SURGERY (ADDED 10/91)</td>
</tr>
<tr>
<td>78</td>
<td>CARDIAC SURGERY (ADDED 10/91)</td>
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79 = ADDICTION MEDICINE (ADDED 10/91)
80 = CLINICAL SOCIAL WORKER (1991)
81 = CRITICAL CARE-INTENSIVISTS (ADDED 10/91)
82 = OPHTHALMOLOGY, CATARACTS SPECIALTY
     (ADDED 10/91)
83 = HEMATOLOGY/ONCOLOGY (ADDED 10/91)
84 = PREVENTIVE MEDICINE (ADDED 10/91)
85 = MAXILLOFACIAL SURGERY (ADDED 10/91)
86 = NEUROPSYCHIATRY (ADDED 10/91)
87 = ALL OTHER (E.G. DRUG AND DEPARTMENT STORES) (REVISED 10/91 TO MEAN ALL OTHER SUPPLIERS)
88 = UNKNOWN (REVISED 10/91 TO MEAN PHYSICIAN ASSISTANT)
90 = MEDICAL ONCOLOGY (ADDED 10/91)
91 = SURGICAL ONCOLOGY (ADDED 10/91)
92 = RADIATION ONCOLOGY (ADDED 10/91)
93 = EMERGENCY MEDICINE (ADDED 10/91)
94 = INTERVENTIONAL RADIOLOGY (ADDED 10/91)
95 = INDEPENDENT PHYSIOLOGICAL LABORATORY
     (ADDED 10/91)
96 = UNKNOWN PHYSICIAN SPECIALTY (ADDED 10/91)
99 = UNKNOWN--INCL. SOCIAL WORKER’S PSYCHIATRIC SERVICES (REVISED 10/91 TO MEAN UNKNOWN SUPPLIER/PROVIDER)
---------------------------------------
**EFFECTIVE 3/92**

00 = CARRIER WIDE
01 = GENERAL PRACTICE
02 = GENERAL SURGERY
03 = ALLERGY/IMMUNOLOGY
04 = OTOLARYNGOLOGY
05 = ANESTHESIOLOGY
06 = CARDIOLOGY
07 = DERMATOLOGY
08 = FAMILY PRACTICE
09 = GYNECOLOGY (OSTEOPATHS ONLY)
    (DISCONTINUED 4/92 USE CODE 16)
10 = GASTROENTEROLOGY
11 = INTERNAL MEDICINE
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<th>Specialty</th>
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<tr>
<td>12</td>
<td>Osteopathic Manipulative Therapy</td>
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<tr>
<td>13</td>
<td>Neurology</td>
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<tr>
<td>14</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>15</td>
<td>Obstetrics (Osteopaths Only)</td>
</tr>
<tr>
<td></td>
<td>(Discontinued 4/92 Use Code 16)</td>
</tr>
<tr>
<td>16</td>
<td>Obstetrics/Gynecology</td>
</tr>
<tr>
<td>17</td>
<td>Ophthalmology, Otolaryngology, Rhinology (Osteopaths Only)</td>
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<tr>
<td></td>
<td>(Discontinued 4/92 Use Codes 18 or 04 Depending on Percentage of Practice)</td>
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<tr>
<td>18</td>
<td>Ophthalmology</td>
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<td>19</td>
<td>Oral Surgery (Dentists Only)</td>
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<td>20</td>
<td>Orthopedic Surgery</td>
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<td>21</td>
<td>Pathologic Anatomy, Clinical Pathology (Osteopaths Only)</td>
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<td></td>
<td>(Discontinued 4/92 Use Code 22)</td>
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<td>22</td>
<td>Pathology</td>
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<td>23</td>
<td>Peripheral Vascular Disease, Medical or Surgical (Osteopaths Only)</td>
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<td>(Discontinued 4/92 Use Code 76)</td>
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<tr>
<td>24</td>
<td>Plastic and Reconstructive Surgery</td>
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<td>25</td>
<td>Physical Medicine and Rehabilitation</td>
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<td>26</td>
<td>Psychiatry</td>
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<td>27</td>
<td>Psychiatry, Neurology (Osteopaths Only)</td>
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<td>(Discontinued 4/92 Use Code 86)</td>
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<td>28</td>
<td>Colorectal Surgery (Formerly Proctology)</td>
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<td>29</td>
<td>Pulmonary Disease</td>
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<td>30</td>
<td>Diagnostic Radiology</td>
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<td>31</td>
<td>Roentgenology, Radiology (Osteopaths Only)</td>
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<td></td>
<td>(Discontinued 4/92 Use Code 30)</td>
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<tr>
<td>32</td>
<td>Radiation Therapy (Osteopaths Only)</td>
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<td>(Discontinued 4/92 Use Code 92)</td>
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<tr>
<td>33</td>
<td>Thoracic Surgery</td>
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<td>34</td>
<td>Urology</td>
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<td>35</td>
<td>Chiropractic</td>
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<td>Nuclear Medicine</td>
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<td>37</td>
<td>Pediatric Medicine</td>
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<td>38</td>
<td>Geriatric Medicine</td>
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<td>39</td>
<td>Nephrology</td>
</tr>
<tr>
<td>40</td>
<td>Hand Surgery</td>
</tr>
</tbody>
</table>
| 41   | Optometry (Revised 10/93 to
MEAN OPTOMETRIST)
42 = CERTIFIED NURSE MIDWIFE (EFF 1/87)
43 = CRNA, ANESTHESIA ASSISTANT
   (EFF 1/87)
44 = INFECTIOUS DISEASE
45 = MAMMOGRAPHY SCREENING CENTER
46 = ENDOCRINOLOGY (EFF 4/92)
48 = PODIATRY
49 = AMBULATORY SURGICAL CENTER
   (FORMERLY MISCELLANEOUS)
50 = NURSE PRACTITIONER
51 = MEDICAL SUPPLY COMPANY WITH
   CERTIFIED ORTHOTIST (CERTIFIED BY
   AMERICAN BOARD FOR CERTIFICATION IN
   PROSTHETICS AND ORTHOTICS)
52 = MEDICAL SUPPLY COMPANY WITH
   CERTIFIED PROSTHETIST
   (CERTIFIED BY AMERICAN BOARD FOR
   CERTIFICATION IN PROSTHETICS AND
   ORTHOTICS)
53 = MEDICAL SUPPLY COMPANY WITH
   CERTIFIED PROSTHETIST-ORTHOTIST
   (CERTIFIED BY AMERICAN BOARD FOR
   CERTIFICATION IN PROSTHETICS
   AND ORTHOTICS)
54 = MEDICAL SUPPLY COMPANY NOT INCLUDED
   IN 51, 52, OR 53. (REVISED 10/93
   TO MEAN MEDICAL SUPPLY COMPANY)
55 = INDIVIDUAL CERTIFIED ORTHOTIST
56 = INDIVIDUAL CERTIFIED PROSTHETIST
57 = INDIVIDUAL CERTIFIED PROSTHETIST-
   ORTHOTIST
58 = INDIVIDUALS NOT INCLUDED IN 55, 56,
   OR 57 (REVISED 10/93 TO MEAN MEDICAL
   SUPPLY COMPANY WITH REGISTERED
   PHARMACIST)
59 = AMBULANCE SERVICE SUPPLIER, E.G.,
   PRIVATE AMBULANCE COMPANIES, FUNERAL
   HOMES, ETC.
60 = PUBLIC HEALTH OR WELFARE AGENCIES
   (FEDERAL, STATE, AND LOCAL)
61 = VOLUNTARY HEALTH OR CHARITABLE
AGENCIES (E.G., NATIONAL CANCER SOCIETY, NATIONAL HEART ASSOCIATION, CATHOLIC CHARITIES)
62 = PSYCHOLOGIST (BILLING INDEPENDENTLY)
63 = PORTABLE X-RAY SUPPLIER
64 = AUDIOLOGIST (BILLING INDEPENDENTLY)
65 = PHYSICAL THERAPIST (INDEPENDENTLY PRACTICING)
66 = RHEUMATOLOGY (EFF 4/92)
67 = OCCUPATIONAL THERAPIST (INDEPENDENTLY PRACTICING)
68 = CLINICAL PSYCHOLOGIST
69 = CLINICAL LABORATORY (BILLING INDEPENDENTLY)
70 = MULTISPECIALTY CLINIC OR GROUP PRACTICE
71 = DIAGNOSTIC X-RAY (GPPP) (NOT TO BE ASSIGNED AFTER 5/92)
72 = DIAGNOSTIC LABORATORY (GPPP) (NOT TO BE ASSIGNED AFTER 5/92)
73 = PHYSIOTHERAPY (GPPP) (NOT TO BE ASSIGNED AFTER 5/92)
74 = OCCUPATIONAL THERAPY (GPPP) (NOT TO BE ASSIGNED AFTER 5/92)
75 = OTHER MEDICAL CARE (GPPP) (NOT TO BE ASSIGNED AFTER 5/92)
76 = PERIPHERAL VASCULAR DISEASE (EFF 4/92)
77 = VASCULAR SURGERY (EFF 4/92)
78 = CARDIAC SURGERY (EFF 4/92)
79 = ADDICTION MEDICINE (EFF 4/92)
80 = LICENSED CLINICAL SOCIAL WORKER
81 = CRITICAL CARE (INTENSIVISTS) (EFF 4/92)
82 = HEMATOLOGY (EFF 4/92)
83 = HEMATOLOGY/ONCOLOGY (EFF 4/92)
84 = PREVENTIVE MEDICINE (EFF 4/92)
85 = MAXILLOFACIAL SURGERY (EFF 4/92)
86 = NEUROPSYCHIATRY (EFF 4/92)
87 = ALL OTHER SUPPLIERS (E.G., DRUG AND DEPARTMENT STORES) (REVISED 10/93 TO MEAN DEPARTMENT STORE)
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<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>88</td>
<td>UNKNOWN SUPPLIER/PROVIDER (REVISED 10/93 TO MEAN GROCERY STORE)</td>
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<tr>
<td>89</td>
<td>CERTIFIED CLINICAL NURSE SPECIALIST</td>
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<td>MEDICAL ONCOLOGY (EFF 4/92)</td>
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<tr>
<td>91</td>
<td>SURGICAL ONCOLOGY (EFF 4/92)</td>
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<tr>
<td>92</td>
<td>RADIATION ONCOLOGY (EFF 4/92)</td>
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<td>93</td>
<td>EMERGENCY MEDICINE (EFF 4/92)</td>
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<td>94</td>
<td>INTERVENTIONAL RADIOLOGY (EFF 4/92)</td>
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<td>95</td>
<td>INDEPENDENT PHYSIOLOGICAL LABORATORY (EFF 4/92)</td>
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<td>96</td>
<td>UNKNOWN PHYSICIAN SPECIALTY (REVISED 10/93 TO MEAN OPTICIAN)</td>
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<td>97</td>
<td>PHYSICIAN ASSISTANT (EFF 5/92)</td>
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<td>99</td>
<td>UNKNOWN SUPPLIER/PROVIDER</td>
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<td>HOSPITAL (EFF 10/93)</td>
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<td>SNF (EFF 10/93)</td>
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<td>INTERMEDIATE CARE NURSING FACILITY (EFF 10/93)</td>
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<td>A3</td>
<td>NURSING FACILITY, OTHER (EFF 10/93)</td>
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<td>HHA (EFF 10/93)</td>
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<td>A5</td>
<td>PHARMACY (EFF 10/93)</td>
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<tr>
<td>A6</td>
<td>MEDICAL SUPPLY COMPANY WITH RESPIRATORY THERAPIST (EFF 10/93)</td>
</tr>
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</table>

SOURCE: MEDICARE PAYMENT RECORDS

72. PHYSICIAN IDENTIFICATION NUMBER  CHAR 9 73 81 THIS FIELD SHOWS THE NUMBER USED TO IDENTIFY INDIVIDUAL PHYSICIANS, GROUPS, OR CLINICS.

SOURCE: ORIGINAL PAYMENT RECORDS

LIMITATIONS: THERE ARE PROBLEMS WITH THE USE OF THIS FIELD DUE TO THE LATITUDE PERMITTED IN ASSIGNMENT.

73. TYPE OF PHYSICIAN IDENTIFICATION NUMBER  CHAR 1 82 82 THIS FIELD DESCRIBES THE TYPE OF PHYSICIAN OR SUPPLIER PROVIDING THE SERVICE AND THE TYPE OF IDENTIFICATION NUMBER BEING USED.

CODES:
1 = PHYSICIAN/SUPPLIER AS SOLO PRACTITIONERS
   SSN USED
2 = PHYSICIAN/SUPPLIER AS SOLO PRACTITIONERS
   CARRIER ID USED
3 = SUPPLIERS OTHER THAN SOLO
   EMPLOYER IDENTIFICATION (EI) NUMBER USED
4 = SUPPLIERS OTHER THAN SOLO
   CARRIER ID USED
5 = HOSPITALS
   EI NUMBER USED
6 = HOSPITALS
   PROVIDER NUMBER USED
7 = CLINICS, GROUPS, ASSOCIATIONS, OR
   PARTNERSHIPS EI NUMBER USED
8 = GROUP PRACTICE PREPAYMENT PLANS
   EI NUMBER USED
0 = CLINICS, GROUPS, ASSOCIATIONS, OR
   PARTNERSHIPS CARRIER ID USED

SOURCE:
ORIGINAL PAYMENT RECORDS

74. DATE PAID  CHAR  5  83  87  DATE REIMBURSEMENT PAYMENT IS APPROVED

5 DIGITS

EDIT-RULES:
YYDDD

SOURCE:
MEDICARE PAYMENT RECORDS