

Health Benefit Plan File Layout

Claims data submission

Revised 07/15/2013

Please note file layout shown below is fixed field. Please carefully read all field descriptions and footnotes. If preferred, file may be submitted in comma separated value (.csv), tab-delimited, Access (.mdb .accdb) or Excel. Fields are limited to the length specified below. If you would like to send data in a format other than the formats listed above, please contact Trina Barton at RRC, (678) 788-7790 or email at trina.barton@riskreg.com

	Field Name ¹	Start	Width	Description
1	COMPANY CODE	1	5	Provide NAIC code or OrgID #. Leading zeros are not required. When providing an OrgID# you must use one of the alternate file formats rather than fixed field format for the complete submission.
2	CLAIM NUMBER	6	20	Claim number to identify claim.
3	LINE NUMBER	26	3	Line number to identify service within claim.
4	DATE OF SERVICE ²	29	8	Date of service for line item. CCYYMMDD
5	DATE RECEIVED ²	37	8	Date received in mailroom. CCYYMMDD
6	FIRST RESPONSE DATE ²	45	8	Date of first response to claimant. First response includes payment, denial, or request for additional information. Date defined by the date response is mailed. If payment or denial, date of payment/denial should be entered in Final Disposition Date field also. (If date is not provided, timeliness statistics will be calculated from received date to final disposition date.) CCYYMMDD
7	FIRST RESPONSE TYPE	53	1	Required if first response date is provided. Type of first response. P - Paid D - Denied R - Request for information N - First response field not provided O - Other (Provide explanation in cover letter)

¹ For alternate formats other than Access, please include field names (column headings) in the first row of data. In Access, the table field names must correspond with the field names in this document. The order of the fields must be maintained.

² Dates in tab-delimited or .csv files should be MM/DD/CCYY format and Excel/Access files should be formatted as a short date field (MM/DD/CCYY).

NOTE: Company Cover Letter must include additional information for fields: 7, 10, 12, 13, 15, 17, 18 and 19, if applicable.

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	Field Name ¹	Start	Width	Description
8	CLAIM COMPLETE DATE ²	54	8	Date that claimant has provided all needed information so that claim is complete. (If date is not provided, timeliness statistics will be calculated from received date to final disposition date.) CCYYMMDD
9	FINAL DISPOSITION DATE ²	62	8	Date of final disposition defined by mail date of correspondence/check or date of electronic transfer. CCYYMMDD
10	FINAL DISPOSITION TYPE	70	1	Type of final disposition. P - Paid D - Denied A - Adjustments (Provide company's definition of adjustments in cover letter) O - Other (Provide explanation in cover letter)
11	FINAL DISPOSITION AMOUNT ³	71	12	Net amount paid for line item after adjustments. Payment amounts should NOT include interest. Payment field must contain 12 numeric characters and be entered in US dollars and cents. The right-most two positions represent cents. Do not enter dollar signs, commas, or decimal points. Negative amounts are indicated by placing a "-" in the left-most position of the payment field. If minus sign is omitted, the number is assumed to be positive. Positive numbers are assumed to be payments and negatives are assumed to recoveries or adjustments. Payment amounts must be right justified.

² Dates in tab-delimited or .csv files should be MM/DD/CCYY format and Excel/Access files should be formatted as a short date field (MM/DD/CCYY).

³ Dollar amount fields must be a number or currency format and must have two decimals. A minus sign must be used to indicate negative values.

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12	PROCESSING ENTITY	83	2	Indicate assigned code for each entity/vendor name and define in the cover letter. (Field MUST include 2 digits) 00 – Managed Care Organization 01 – Vendor/Entity #1 02 – Vendor/Entity #2 (Assign codes for each additional 3 rd party vendor as needed)
13	TYPE OF CLAIM	85	1	Claim type indicator: A - Comprehensive (hospital & medical) B - Medicare supplement C - Dental D - Vision E - Federal employees health benefits plan F - Medicare G - Medicaid H - Other health I - Self insured (ASO/ASC) J - Pharmacy K – Other (Provide explanation in cover letter)
14	METHOD OF SUBMISSION	86	1	E – Electronic claim submission P – Paper claim submission
15	INTEREST PAID	87	1	Indicator to show if interest was paid for the line item. N - No Y – Yes, in accordance with §33-24-59.5 or §33-21A-7(c) O - Not in accordance with §33-24-59.5 or §33-21A-7(c), but paid to meet another standard (Please define standard in cover letter)
16	INTEREST AMOUNT ³	88	12	Amount of interest paid on claim line or pro-rata amount attributable to the claim line if paid on an aggregate basis. – See Field 11 for specific formatting instructions

³ Dollar amount fields must be a number or currency format and must have two decimals. A minus sign must be used to indicate negative values.

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17	GENERAL USE FIELD ONE	100	10	Field available to provide additional information as necessary. Please explain contents in cover letter.
18	GENERAL USE FIELD TWO	110	10	Field available to provide additional information as necessary. Please explain contents in cover letter.
19	GENERAL USE FIELD THREE	120	10	Field available to provide additional information as necessary. Please explain contents in cover letter.

NOTE: Company Cover Letter must include additional information for fields: 7, 10, 12, 13, 15, 17, 18 and 19, if applicable.