

**Fields: Sheps Center Medicaid data**

| Category  | Field                            | Field - Literal            | Format       | Length | Institutional            | Professional             | Pharmacy                 | Dental                   | CapMgmt                  |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
|---|----------------------------------|----------------------------|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|---------------|---|-------------------------------|---|------------------|---|--------|---|----------------------------------|---|-------------|---|------------------------------|---|---------------------|---|------|---|-------|-------|---------------|
| Claims-Patient  | Alternate Member ID Encrypted    | ALT_MBR_ID_ENCRYPT         | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| Claims-Patient  | Basis of Cost Determination      | NCPDP_BASIS_OF_CST_DTRM_CD | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| <table border="1"> <tbody> <tr><td>0</td><td>Not Specified</td></tr> <tr><td>1</td><td>AWP (Average Wholesale Price)</td></tr> <tr><td>2</td><td>Local Wholesaler</td></tr> <tr><td>3</td><td>Direct</td></tr> <tr><td>4</td><td>EAC (Estimated Acquisition Cost)</td></tr> <tr><td>5</td><td>Acquisition</td></tr> <tr><td>6</td><td>MAC (Maximum Allowable Cost)</td></tr> <tr><td>7</td><td>Usual And Customary</td></tr> <tr><td>8</td><td>340B</td></tr> <tr><td>9</td><td>Other</td></tr> <tr><td>SPACE</td><td>Not Specified</td></tr> </tbody> </table> |                                  |                            |              |        |                          |                          |                          |                          |                          | 0 | Not Specified | 1 | AWP (Average Wholesale Price) | 2 | Local Wholesaler | 3 | Direct | 4 | EAC (Estimated Acquisition Cost) | 5 | Acquisition | 6 | MAC (Maximum Allowable Cost) | 7 | Usual And Customary | 8 | 340B | 9 | Other | SPACE | Not Specified |
| 0   | Not Specified                    |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| 1   | AWP (Average Wholesale Price)    |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| 2   | Local Wholesaler                 |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| 3   | Direct                           |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| 4   | EAC (Estimated Acquisition Cost) |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| 5   | Acquisition                      |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| 6   | MAC (Maximum Allowable Cost)     |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| 7   | Usual And Customary              |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| 8   | 340B                             |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| 9   | Other                            |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| SPACE   | Not Specified                    |                            |              |        |                          |                          |                          |                          |                          |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| Claims-Patient  | Health Plan Description          | MBR_HLTHPLN_DESC           | Alphanumeric | 200    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |
| Claims-Patient  | Health Plan ID                   | MBR_HLTHPLN_ID             | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |               |   |                               |   |                  |   |        |   |                                  |   |             |   |                              |   |                     |   |      |   |       |       |               |

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| Category       | Field                   | Field - Literal  | Format       | Length | Institutional            | Professional             | Pharmacy                 | Dental                   | CapMgmt                    |
|----------------|-------------------------|--|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------|
| Claims-Patient | Living Arrangement Code | MBR_LIV_ARRGMNT_CD   | Alphanumeric | 20     | Y                        | Y                        |                          | Y                        |                            |
|                | 10                      | Private Living Arrangement (Not 1/3 Reduction)                           |              |        |                          |                          |                          |                          |                            |
|                | 11                      | Private Living Arr (With 1/3 Reduction) (Medicaid)                       |              |        |                          |                          |                          |                          |                            |
|                | 12                      | Living With Another Work First Family                                    |              |        |                          |                          |                          |                          |                            |
|                | 13                      | Living With SSI Recipient(s)   |              |        |                          |                          |                          |                          |                            |
|                | 14                      | Pace Private Living Arrangement  |              |        |                          |                          |                          |                          |                            |
|                | 15                      | Pace Living With SSI Recipient(s)  |              |        |                          |                          |                          |                          |                            |
|                | 16                      | Medicaid Suspended ? State Incarceration                                 |              |        |                          |                          |                          |                          |                            |
|                | 17                      | Medicaid Suspended - Instit For Mental Diseases (LMD)                    |              |        |                          |                          |                          |                          |                            |
|                | 18                      | Medicaid Suspended ? SA Facility Classified As Instit For Mental Disease |              |        |                          |                          |                          |                          |                            |
|                | 19                      | Medicaid Suspended ? County/Local Incarceration                          |              |        |                          |                          |                          |                          |                            |
|                | 50                      | Skilled Nursing Facility   |              |        |                          |                          |                          |                          |                            |
|                | 51                      | Domiciliary Care, 5 Or Fewer Beds (SAA, SAD, MSB)                        |              |        |                          |                          |                          |                          |                            |
|                | 52                      | Domiciliary Care, 6 Or More Beds (SAA, SAD, MSB)                         |              |        |                          |                          |                          |                          |                            |
|                | 53                      | Foster Care (MAF, MIC, HSF, IAS)   |              |        |                          |                          |                          |                          |                            |
|                | 54                      | Pace Living In Nursing Facility  |              |        |                          |                          |                          |                          |                            |
|                | 56                      | Adult Group Home (SAA, SAD, MSB, MAF, MRF)                               |              |        |                          |                          |                          |                          |                            |
|                | 57                      | Children's Grp Home (MSB, MAF, MIC, MAF, HSF, IAS)                       |              |        |                          |                          |                          |                          |                            |
|                | 58                      | Intermediate Care Facility   |              |        |                          |                          |                          |                          |                            |
|                | 59                      | Intermediate Care Facility/Mental Retardation Ctr                        |              |        |                          |                          |                          |                          |                            |
|                | 60                      | Hos, Over 30Days/Psych Res Treat-Facility (PRTF)                         |              |        |                          |                          |                          |                          |                            |
|                | 70                      | Cherry Hospital  |              |        |                          |                          |                          |                          |                            |
|                | 71                      | Dorothea Dix Hospital  |              |        |                          |                          |                          |                          |                            |
|                | 72                      | Umstead Hospital   |              |        |                          |                          |                          |                          |                            |
|                | 73                      | Broughton Hospital   |              |        |                          |                          |                          |                          |                            |
|                | 75                      | Other Medical Institution  |              |        |                          |                          |                          |                          |                            |
|                | 76                      | Central Regional Hospital  |              |        |                          |                          |                          |                          |                            |
|                | 80                      | Adoptive Home (MAF, MIC, MRF, HSF, IAS)                                  |              |        |                          |                          |                          |                          |                            |
| Claims-Patient | Managed Care Cohort ID  | MNG_CAR_COHORT_ID  | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Y |

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|----------------|------------------------------|--|--------------|--------|---------------|--------------|----------|--------|---------|
| Claims-Patient | Medicaid Classification Code | MBR_MCAID_CLSFN_CD                                 | Alphanumeric | 20     | Y             | Y            | Y        | Y      | Y       |
|                | 1                            | Used Only As MIC-1) 185-200% (<1) 133-200% (1-5)   |              |        |               |              |          |        |         |
|                | A                            | No Enrollment Fee, NA And Alaskans (< 150 FPL)     |              |        |               |              |          |        |         |
|                | B                            | Categorically Needy (Used Only With MAABD Or MQB)  |              |        |               |              |          |        |         |
|                | C                            | Categorically Needy                                |              |        |               |              |          |        |         |
|                | D                            | Used Only As MAF-D ? Limited To Family Planning    |              |        |               |              |          |        |         |
|                | E                            | Qualifying Individual (Used Only With MQB).        |              |        |               |              |          |        |         |
|                | F                            | No Money Pay ? Emerg-Ser For Non-Qualified Aliens  |              |        |               |              |          |        |         |
|                | G                            | No Money Payment ? Full-Cov For Qualified Aliens   |              |        |               |              |          |        |         |
|                | H                            | No Money Payment ? Emerg-Ser For Qualified Aliens  |              |        |               |              |          |        |         |
|                | I                            | No Money Payment ? Full Cov For Pregnant Alien     |              |        |               |              |          |        |         |
|                | J                            | No Enrollment Fee Others                           |              |        |               |              |          |        |         |
|                | K                            | Enrollment Fee Applicable                          |              |        |               |              |          |        |         |
|                | L                            | Optional ECG                                       |              |        |               |              |          |        |         |
|                | M                            | Medically Needy                                    |              |        |               |              |          |        |         |
|                | N                            | Categorically Needy- No Money Payment              |              |        |               |              |          |        |         |
|                | O                            | Medically Needy - Emerg-Ser Non-Qualified Aliens   |              |        |               |              |          |        |         |
|                | P                            | Medically Needy ? Full Cov For Qualified Aliens    |              |        |               |              |          |        |         |
|                | Q                            | Used Only With Dually Eligible Cases Or M-QB Cases |              |        |               |              |          |        |         |
|                | R                            | Medically Needy - Emerg-Ser For Qualified Aliens   |              |        |               |              |          |        |         |
|                | S                            | No Enrollment Fee, NA And Alaskans (>150 FPL)      |              |        |               |              |          |        |         |
|                | T                            | Full Coverage                                      |              |        |               |              |          |        |         |
|                | U                            | Emergency Coverage (Qualified Alien)               |              |        |               |              |          |        |         |
|                | V                            | Emergency Coverage                                 |              |        |               |              |          |        |         |
|                | W                            | Full Regular Coverage (Non-Alien)                  |              |        |               |              |          |        |         |
|                | X                            | Not Applicable To The Case                         |              |        |               |              |          |        |         |
| Claims-Patient | Member Age                   | MBR_AGE_NBR  | Numeric      | 8      | Y             | Y            | Y        | Y      | Y       |
| Claims-Patient | Member City                  | MBR_REF_CTY  | Alphanumeric | 50     | Y             | Y            | Y        | Y      | Y       |
| Claims-Patient | Member Country Description   | MBR_REF_CNTRY_DESC                                 | Alphanumeric | 200    | Y             | Y            | Y        | Y      | Y       |
| Claims-Patient | Member County Code           | MBR_REF_CNTY_CD                                    | Alphanumeric | 20     | Y             | Y            | Y        | Y      | Y       |
| Claims-Patient | Member County Name           | MBR_REF_CNTY_NM                                    | Alphanumeric | 40     | Y             | Y            | Y        | Y      | Y       |

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|---|---|--------------------------|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------|--|--|--|--|--|
| Claims-Patient  | Member Date of Birth                        | MBR_DOB_DT               | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Eligibility Authorization Begin Date | MBR_REF_ELGB_AUTH_BGN_DT | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Eligibility Begin Date               | MBR_REF_ELGB_BGN_DT      | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Eligibility Coverage Code            | MBR_REF_ELGB_CVRG_CD     | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Eligibility Coverage Description     | MBR_REF_ELGB_CVRG_DESC   | Alphanumeric | 200    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Eligibility End Date                 | MBR_REF_ELGB_END_DT      | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Gender Code                          | HDRPR_MBR_GNDR_CD        | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| <table border="1"> <tr><td>F</td><td>Female</td></tr> <tr><td>M</td><td>Male</td></tr> <tr><td>U</td><td>Unknown</td></tr> </table> |   |                          |              |        | F                        | Female                   | M                        | Male                     | U                        | Unknown |  |  |  |  |  |
| F   | Female                                      |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| M   | Male  |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| U   | Unknown                                     |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| Claims-Patient  | Member Gender Code                          | HDRRX_MBR_GNDR_CD        | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| <table border="1"> <tr><td>F</td><td>Female</td></tr> <tr><td>M</td><td>Male</td></tr> <tr><td>U</td><td>Unknown</td></tr> </table> |   |                          |              |        | F                        | Female                   | M                        | Male                     | U                        | Unknown |  |  |  |  |  |
| F   | Female                                      |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| M   | Male  |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| U   | Unknown                                     |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| Claims-Patient  | Member Gender Code                          | HDRDENTAL_MBR_GNDR_CD    | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| <table border="1"> <tr><td>F</td><td>Female</td></tr> <tr><td>M</td><td>Male</td></tr> <tr><td>U</td><td>Unknown</td></tr> </table> |   |                          |              |        | F                        | Female                   | M                        | Male                     | U                        | Unknown |  |  |  |  |  |
| F   | Female                                      |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| M   | Male  |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| U   | Unknown                                     |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| Claims-Patient  | Member Gender Code                          | HDRIN_MBR_GNDR_CD        | Alphanumeric | 1      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| <table border="1"> <tr><td>F</td><td>Female</td></tr> <tr><td>M</td><td>Male</td></tr> <tr><td>U</td><td>Unknown</td></tr> </table> |   |                          |              |        | F                        | Female                   | M                        | Male                     | U                        | Unknown |  |  |  |  |  |
| F   | Female                                      |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| M   | Male  |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| U   | Unknown                                     |                          |              |        |                          |                          |                          |                          |                          |         |  |  |  |  |  |
| Claims-Patient  | Member Gender Description                   | HDRPR_MBR_GNDR_DESC      | Alphanumeric | 200    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Gender Description                   | HDRRX_MBR_GNDR_DESC      | Alphanumeric | 200    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Gender Description                   | HDRDENTAL_MBR_GNDR_DESC  | Alphanumeric | 200    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Gender Description                   | HDRIN_MBR_GNDR_DESC      | Alphanumeric | 200    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Group Number                         | MBR_BNFT_SVC_GRP_ID      | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member Living Arrangement Description       | MBR_LIV_ARRGMNT_DESC     | Alphanumeric | 200    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |
| Claims-Patient  | Member State Code                           | MBR_REF_ST_ABBREV        | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |  |  |  |  |  |

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|---|---------------------|-----------------|--------------|--------|---------------|--------------|----------|--------|---------|---|---------------|---|--------------|---|----------|-------|-------|
| Claims-Patient  | Member Zip Code     | MBR_REF_ZIP_CD  | Alphanumeric | 20     | Y             | Y            | Y        | Y      | Y       |   |               |   |              |   |          |       |       |
| Claims-Patient  | Pregnancy Indicator | MBR_PRGNCY_IND  | Alphanumeric | 1      | Y             | Y            | Y        | Y      |         |   |               |   |              |   |          |       |       |
| <table border="1"> <tr> <td>0</td> <td>Not Specified</td> </tr> <tr> <td>1</td> <td>Not Pregnant</td> </tr> <tr> <td>2</td> <td>Pregnant</td> </tr> <tr> <td>Space</td> <td>Blank</td> </tr> </table> |                     |                 |              |        |               |              |          |        |         | 0 | Not Specified | 1 | Not Pregnant | 2 | Pregnant | Space | Blank |
| 0   | Not Specified       |                 |              |        |               |              |          |        |         |   |               |   |              |   |          |       |       |
| 1   | Not Pregnant        |                 |              |        |               |              |          |        |         |   |               |   |              |   |          |       |       |
| 2   | Pregnant            |                 |              |        |               |              |          |        |         |   |               |   |              |   |          |       |       |
| Space   | Blank               |                 |              |        |               |              |          |        |         |   |               |   |              |   |          |       |       |
| Claims-Patient  | SSI Status Code     | MBR_SSI_STAT_CD | Alphanumeric | 20     | Y             | Y            | Y        | Y      | Y       |   |               |   |              |   |          |       |       |
| <table border="1"> <tr> <td>N</td> <td>No</td> </tr> <tr> <td>Y</td> <td>Yes</td> </tr> </table>  |                     |                 |              |        |               |              |          |        |         | N | No            | Y | Yes          |   |          |       |       |
| N   | No                  |                 |              |        |               |              |          |        |         |   |               |   |              |   |          |       |       |
| Y   | Yes                 |                 |              |        |               |              |          |        |         |   |               |   |              |   |          |       |       |

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| Category    | Field                                    | Field - Literal | Format       | Length | Institutional                       | Professional                        | Pharmacy                            | Dental                              | CapMgmt                             |
|-------------|--|-----------------|--------------|--------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Claims-Time | Admission Date                           | ADMSN_DT        | Numeric      | 8      | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Time | Calculated Days Number                   | CALCD_DAY_NBR   | Numeric      | 8      | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Time | Claim Header Paid Date                   | CLM_HDR_PD_DT   | Numeric      | 8      | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Time | Claim Line Number                        | CLM_LNE_NBR     | Numeric      | 8      | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Time | Date of latest Medicaid extract included | LAST_XTRCT_DT   | Alphanumeric | 6      | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Time | Discharge Date                           | DSCHRG_DT       | Numeric      | 8      | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Claims-Time | Line Ending Date of Service              | LNE_SVC_END_DT  | Numeric      | 8      | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Time | Line Starting Date of Service            | LNE_SVC_BGN_DT  | Numeric      | 8      | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Time | Number of Days Covered                   | CVR_DAY_NBR     | Numeric      | 8      | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Claims-Time | Prescribed Date                          | DRUG_RX_DT      | Numeric      | 8      | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |

Fields: Sheps Center Medicaid data

| Category   | Field  | Field - Literal | Format       | Length | Institutional                       | Professional                        | Pharmacy                 | Dental                              | CapMgmt                             |   |                           |   |                           |   |                            |   |   |   |                       |
|--|--|-----------------|--------------|--------|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|---|---------------------------|---|---------------------------|---|----------------------------|---|---|---|-----------------------|
| Claims-Clinical  | Adjudicated Procedure Code                         | PROC_ADJDC_CD   | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Admitting Diagnosis Code                           | ADMT_DIAG_CD    | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Admitting Diagnosis Present on Admission Indicator | DIAG_PRI_POA_CD | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| <table border="0"> <tr> <td style="width: 5%;">1</td> <td>Exempt From POA Reporting</td> </tr> <tr> <td>N</td> <td>Diagnosis Was Not Present</td> </tr> <tr> <td>U</td> <td>Documentation Insufficient</td> </tr> <tr> <td>W</td> <td>Clinically Undetermined If Diag Was Present</td> </tr> <tr> <td>Y</td> <td>Diagnosis Was Present</td> </tr> </table> |  |                 |              |        |                                     |                                     |                          |                                     |                                     | 1 | Exempt From POA Reporting | N | Diagnosis Was Not Present | U | Documentation Insufficient | W | Clinically Undetermined If Diag Was Present | Y | Diagnosis Was Present |
| 1  | Exempt From POA Reporting                          |                 |              |        |                                     |                                     |                          |                                     |                                     |   |                           |   |                           |   |                            |   |   |   |                       |
| N  | Diagnosis Was Not Present                          |                 |              |        |                                     |                                     |                          |                                     |                                     |   |                           |   |                           |   |                            |   |   |   |                       |
| U  | Documentation Insufficient                         |                 |              |        |                                     |                                     |                          |                                     |                                     |   |                           |   |                           |   |                            |   |   |   |                       |
| W  | Clinically Undetermined If Diag Was Present        |                 |              |        |                                     |                                     |                          |                                     |                                     |   |                           |   |                           |   |                            |   |   |   |                       |
| Y  | Diagnosis Was Present                              |                 |              |        |                                     |                                     |                          |                                     |                                     |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Dental First Cavity Code                           | DNTL_CVTY_CD    | Alphanumeric | 20     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 1                                   | DIAG_CD_01      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 1 Description                       | DIAG_CD_01_DESC | Alphanumeric | 200    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 10                                  | DIAG_CD_10      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 10 Description                      | DIAG_CD_10_DESC | Alphanumeric | 200    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 2                                   | DIAG_CD_02      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 2 Description                       | DIAG_CD_02_DESC | Alphanumeric | 200    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 3                                   | DIAG_CD_03      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 3 Description                       | DIAG_CD_03_DESC | Alphanumeric | 200    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 4                                   | DIAG_CD_04      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 4 Description                       | DIAG_CD_04_DESC | Alphanumeric | 200    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 5                                   | DIAG_CD_05      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 5 Description                       | DIAG_CD_05_DESC | Alphanumeric | 200    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 6                                   | DIAG_CD_06      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 6 Description                       | DIAG_CD_06_DESC | Alphanumeric | 200    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 7                                   | DIAG_CD_07      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 7 Description                       | DIAG_CD_07_DESC | Alphanumeric | 200    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 8                                   | DIAG_CD_08      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 8 Description                       | DIAG_CD_08_DESC | Alphanumeric | 200    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |
| Claims-Clinical  | Diagnosis Code 9                                   | DIAG_CD_09      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |   |                           |   |                           |   |                            |   |   |   |                       |

**Fields: Sheps Center Medicaid data**

| Category        | Field  | Field - Literal           | Format       | Length | Institutional                       | Professional                        | Pharmacy                 | Dental                              | CapMgmt                  |
|-----------------|--|---------------------------|--------------|--------|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|--------------------------|
| Claims-Clinical | Diagnosis Code 9 Description                       | DIAG_CD_09_DESC           | Alphanumeric | 200    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Claims-Clinical | Diagnosis Related Group                            | DRG_CD                    | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| Claims-Clinical | Diagnosis Related Group DRG Grouper Version Number | DRG_DRG_GRPR_VER_NBR      | Alphanumeric | 30     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                 | 23   | DRG Grouper Version 23.   |              |        |                                     |                                     |                          |                                     |                          |
|                 | 24   | DRG Grouper Version 24.   |              |        |                                     |                                     |                          |                                     |                          |
|                 | 25   | DRG Grouper Version 25.1. |              |        |                                     |                                     |                          |                                     |                          |
|                 | 26   | DRG Grouper Version 26.   |              |        |                                     |                                     |                          |                                     |                          |
|                 | 27   | DRG Grouper Version 27.   |              |        |                                     |                                     |                          |                                     |                          |
| Claims-Clinical | ICD Version Code                                   | ICD_VER_CD                | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
|                 | 0  | ICD-10                    |              |        |                                     |                                     |                          |                                     |                          |
|                 | 9  | ICD-9                     |              |        |                                     |                                     |                          |                                     |                          |
| Claims-Clinical | Procedure modifier 1                               | PROC_MOD_1_CD             | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Claims-Clinical | Procedure modifier 1 Description                   | PROC_MOD_1_DESC           | Alphanumeric | 80     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Claims-Clinical | Procedure modifier 2                               | PROC_MOD_2_CD             | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Claims-Clinical | Procedure modifier 2 Description                   | PROC_MOD_2_DESC           | Alphanumeric | 80     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Claims-Clinical | Procedure modifier 3                               | PROC_MOD_3_CD             | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Claims-Clinical | Procedure modifier 3 Description                   | PROC_MOD_3_DESC           | Alphanumeric | 80     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Claims-Clinical | Procedure modifier 4                               | PROC_MOD_4_CD             | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Claims-Clinical | Procedure modifier 4 Description                   | PROC_MOD_4_DESC           | Alphanumeric | 80     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Claims-Clinical | Reference Diagnosis Code 1_Reason for Visit        | RSN_VST_DIAG_CD           | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| Claims-Clinical | Reference Diagnosis Code 2_Reason for Visit        | RSN_VST_DIAG_2_CD         | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| Claims-Clinical | Reference Diagnosis Code 3_Reason for Visit        | RSN_VST_DIAG_3_CD         | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |



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| Category   | Field  | Field - Literal           | Format       | Length | Institutional            | Professional             | Pharmacy                 | Dental                   | CapMgmt                  |   |        |   |                |   |         |
|--|--|---------------------------|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|--------|---|----------------|---|---------|
| Claims-Provider  | Attending Provider City                        | ATND_PRVDR_REF_CTY        | Alphanumeric | 80     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider County Code                 | ATND_PRVDR_REF_CNTY_CD    | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider County Name                 | ATND_PRVDR_REF_CNTY_NM    | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider First Name                  | ATND_PRVDR_REF_FRST_NM    | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider Identification Number       | ATND_PRVDR_ID             | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider Last Name                   | ATND_PRVDR_REF_LST_NM     | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider Location Code               | ATND_PRVDR_LOC_CD         | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| <table border="1"> <tr> <td>1</td> <td>Pay-To</td> </tr> <tr> <td>2</td> <td>Correspondence</td> </tr> <tr> <td>3</td> <td>Service</td> </tr> </table> |  |                           |              |        |                          |                          |                          |                          |                          | 1 | Pay-To | 2 | Correspondence | 3 | Service |
| 1  | Pay-To   |                           |              |        |                          |                          |                          |                          |                          |   |        |   |                |   |         |
| 2  | Correspondence                                 |                           |              |        |                          |                          |                          |                          |                          |   |        |   |                |   |         |
| 3  | Service  |                           |              |        |                          |                          |                          |                          |                          |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider Medicaid Legacy Provider ID | ATND_PRVDR_REF_ALT_ID     | Alphanumeric | 15     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider Middle Name                 | ATND_PRVDR_REF_MDL_NM     | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider NPI                         | ATND_PRVDR_NPI            | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider State                       | ATND_PRVDR_REF_ST_CD      | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Attending Provider zip                         | ATND_PRVDR_REF_ZIP_CD     | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Billing Provider Atypical NPI                  | BILL_PRVDR_ATYP_PRVDR_NBR | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Billing Provider City                          | BILL_PRVDR_CTY            | Alphanumeric | 25     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Billing Provider County Code                   | BILL_PRVDR_REF_CNTY_CD    | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Billing Provider County Name                   | BILL_PRVDR_REF_CNTY_NM    | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Billing Provider First Name                    | BILL_PRVDR_REF_FRST_NM    | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Billing Provider Identification Number         | BILL_PRVDR_ID             | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Billing Provider Last Name                     | BILL_PRVDR_REF_LST_NM     | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Billing Provider Location Code                 | BILL_PRVDR_LOC_CD         | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| <table border="1"> <tr> <td>1</td> <td>Pay-To</td> </tr> <tr> <td>2</td> <td>Correspondence</td> </tr> <tr> <td>3</td> <td>Service</td> </tr> </table> |  |                           |              |        |                          |                          |                          |                          |                          | 1 | Pay-To | 2 | Correspondence | 3 | Service |
| 1  | Pay-To   |                           |              |        |                          |                          |                          |                          |                          |   |        |   |                |   |         |
| 2  | Correspondence                                 |                           |              |        |                          |                          |                          |                          |                          |   |        |   |                |   |         |
| 3  | Service  |                           |              |        |                          |                          |                          |                          |                          |   |        |   |                |   |         |
| Claims-Provider  | Billing Provider Medicaid Legacy Provider ID   | BILL_PRVDR_REF_ALT_ID     | Alphanumeric | 15     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Billing Provider Middle Name                   | BILL_PRVDR_REF_MDL_NM     | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |

**Fields: Sheps Center Medicaid data**

| Category        | Field  | Field - Literal          | Format       | Length | Institutional                       | Professional                        | Pharmacy                            | Dental                              | CapMgmt                             |
|-----------------|--|--------------------------|--------------|--------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Claims-Provider | Billing Provider Name                            | HDRPR_BILL_PRVDR_NM      | Alphanumeric | 40     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Billing Provider Name                            | HDRIN_BILL_PRVDR_NM      | Alphanumeric | 40     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Billing Provider Name                            | HDRDENTAL_BILL_PRVDR_NM  | Alphanumeric | 40     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Claims-Provider | Billing Provider NPI                             | BILL_PRVDR_NPI           | Alphanumeric | 30     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Provider | Billing Provider State Code                      | BILL_PRVDR_ST_CD         | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Provider | Billing Provider Status Code                     | BILL_PRVDR_REF_STAT_CD   | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|                 | 1  | Active                   |              |        |                                     |                                     |                                     |                                     |                                     |
|                 | 2  | Terminated               |              |        |                                     |                                     |                                     |                                     |                                     |
|                 | 3  | Suspended                |              |        |                                     |                                     |                                     |                                     |                                     |
| Claims-Provider | Billing Provider Taxonomy Code                   | BILL_PRVDR_TXNMY_CD      | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Provider | Billing Provider Taxonomy Qualifier Code         | BILL_PRVDR_TXNMY_QLFR_CD | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Provider | Billing Provider Title                           | BILL_PRVDR_REF_TITL      | Alphanumeric | 30     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Provider | Billing Provider Zip Code                        | BILL_PRVDR_ZIP_CD        | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Claims-Provider | Operating Provider First Name                    | OPRT_PRVDR_REF_FRST_NM   | Alphanumeric | 40     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Operating Provider Identification Number         | OPRT_PRVDR_ID            | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Operating Provider Last Name                     | OPRT_PRVDR_REF_LST_NM    | Alphanumeric | 40     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Operating Provider Middle Name                   | OPRT_PRVDR_REF_MDL_NM    | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Operating Provider NPI                           | OPRT_PRVDR_NPI           | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Operating Provider Title                         | OPRT_PRVDR_REF_TITL      | Alphanumeric | 30     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Prescribing Provider First Name                  | PRSCR_PRVDR_REF_FRST_NM  | Alphanumeric | 40     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Prescribing Provider Identification Number       | PRSCR_PRVDR_ID           | Alphanumeric | 30     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Prescribing Provider Last Name                   | PRSCR_PRVDR_REF_LST_NM   | Alphanumeric | 40     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Prescribing Provider Medicaid Legacy Provider ID | PRSCR_PRVDR_REF_ALT_ID   | Alphanumeric | 15     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Prescribing Provider Middle Name                 | PRSCR_PRVDR_REF_MDL_NM   | Alphanumeric | 20     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Prescribing Provider NPI                         | PRSCR_PRVDR_NPI          | Alphanumeric | 20     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Provider | Referring Provider First Name                    | RFR_PRVDR_REF_FRST_NM    | Alphanumeric | 40     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Claims-Provider | Referring Provider Identification Number         | LINE_RFR_PRVDR_ID        | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Claims-Provider | Referring Provider Identification Number         | HDRIN_RFR_PRVDR_ID       | Alphanumeric | 30     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

Fields: Sheps Center Medicaid data

| Category        | Field  | Field - Literal             | Format       | Length | Institutional            | Professional             | Pharmacy                 | Dental                   | CapMgmt                  |
|-----------------|--|-----------------------------|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Claims-Provider | Referring Provider Last Name                   | RFR_PRVDR_REF_LST_NM        | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Referring Provider Middle Name                 | RFR_PRVDR_REF_MDL_NM        | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Referring Provider NPI                         | LINE_RFR_PRVDR_NPI          | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Referring Provider NPI                         | HDRIN_RFR_PRVDR_NPI         | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Referring Provider Taxonomy                    | RFR_PRVDR_TXNMY_CD          | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Referring Provider Title                       | RFR_PRVDR_REF_TITL          | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Atypical NPI                | RNDR_PRVDR_REF_ATYPICAL_NPI | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider City                        | RNDR_PRVDR_REF_CTY          | Alphanumeric | 80     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider County Code                 | RNDR_PRVDR_REF_CNTY_CD      | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider County Name                 | RNDR_PRVDR_REF_CNTY_NM      | Alphanumeric | 1000   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Date of Death               | RNDR_PRVDR_REF_DTH_DT       | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider First Name                  | RNDR_PRVDR_REF_FRST_NM      | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Identification Number       | RNDR_PRVDR_ID               | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Last Name                   | RNDR_PRVDR_REF_LST_NM       | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Location Code               | RNDR_PRVDR_LOC_CD           | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Medicaid Legacy Provider ID | RNDR_PRVDR_REF_ALT_ID       | Alphanumeric | 15     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Middle Name                 | RNDR_PRVDR_REF_MDL_NM       | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider NPI                         | RNDR_PRVDR_NPI              | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Site Location Name          | RNDR_PRVDR_REF_SVC_LOC_NM   | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider State                       | RNDR_PRVDR_REF_ST_CD        | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Status Code                 | RNDR_PRVDR_REF_STAT_CD      | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                 | 1  | Active                      |              |        |                          |                          |                          |                          |                          |
|                 | 2  | Terminated                  |              |        |                          |                          |                          |                          |                          |
|                 | 3  | Suspended                   |              |        |                          |                          |                          |                          |                          |
| Claims-Provider | Rendering Provider Status Effective Date       | RNDR_PRVDR_REF_STAT_EFF_DT  | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Status End Date             | RNDR_PRVDR_REF_STAT_END_DT  | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Taxonomy                    | RNDR_PRVDR_TXNMY_CD         | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Provider | Rendering Provider Title                       | RNDR_PRVDR_REF_TITL         | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Fields: Sheps Center Medicaid data**

| Category   | Field   | Field - Literal       | Format       | Length | Institutional            | Professional             | Pharmacy                 | Dental                   | CapMgmt                  |   |        |   |                |   |         |
|--|---|-----------------------|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|--------|---|----------------|---|---------|
| Claims-Provider  | Rendering Provider Zip                            | RNDR_PRVDR_REF_ZIP_CD | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility NPI                            | SVC_PRVDR_NPI         | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility Provider City                  | SVC_PRVDR_REF_CTY     | Alphanumeric | 80     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility Provider County Code           | SVC_PRVDR_REF_CNTY_NM | Alphanumeric | 1000   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility Provider County Code           | SVC_PRVDR_REF_CNTY_CD | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility Provider First Name            | SVC_PRVDR_REF_FRST_NM | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility Provider Identification Number | SVC_PRVDR_ID          | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility Provider Last Name             | SVC_PRVDR_REF_LST_NM  | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility Provider Location Code         | SVC_PRVDR_LOC_CD      | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| <table border="0" style="width: 100%;"> <tr> <td style="width: 20px;">1</td> <td>Pay-To</td> </tr> <tr> <td>2</td> <td>Correspondence</td> </tr> <tr> <td>3</td> <td>Service</td> </tr> </table> |   |                       |              |        |                          |                          |                          |                          |                          | 1 | Pay-To | 2 | Correspondence | 3 | Service |
| 1  | Pay-To  |                       |              |        |                          |                          |                          |                          |                          |   |        |   |                |   |         |
| 2  | Correspondence                                    |                       |              |        |                          |                          |                          |                          |                          |   |        |   |                |   |         |
| 3  | Service   |                       |              |        |                          |                          |                          |                          |                          |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility Provider Middle Name           | SVC_PRVDR_REF_MDL_NM  | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility Provider State                 | SVC_PRVDR_REF_ST_CD   | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |
| Claims-Provider  | Servicing Facility Provider Zip                   | SVC_PRVDR_REF_ZIP_CD  | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |        |   |                |   |         |

Fields: Sheps Center Medicaid data

| Category   | Field                        | Field - Literal         | Format       | Length | Institutional            | Professional             | Pharmacy | Dental                   | CapMgmt                  |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
|--|------------------------------|-------------------------|--------------|--------|--------------------------|--------------------------|----------|--------------------------|--------------------------|---|-------------------------|---|---------------|---|--------------|---|-------------------|-------|---------------------|-------|------------|----|---------|
| Claims-Drug  | Days Supply                  | PD_DAY_SPLY_CT          | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| Claims-Drug  | Dispensed As Written Code    | DSPN_AS_WRTN_CD         | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| Claims-Drug  | Dispensing Fee Amount        | TTL_DSPN_FEE_AMT        | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| Claims-Drug  | Drug Formulary Coverage Code | DRUG_REF_FRMLRY_CVRG_CD | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| <table border="1"> <tr><td>1</td><td>Prior Approval Required</td></tr> <tr><td>C</td><td>Covered</td></tr> <tr><td>N</td><td>Not Covered</td></tr> <tr><td>R</td><td>Preferred Drug</td></tr> <tr><td>SPACE</td><td>Not Covered (Space)</td></tr> </table>   |                              |                         |              |        |                          |                          |          |                          |                          | 1 | Prior Approval Required | C | Covered       | N | Not Covered  | R | Preferred Drug    | SPACE | Not Covered (Space) |       |            |    |         |
| 1  | Prior Approval Required      |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| C  | Covered                      |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| N  | Not Covered                  |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| R  | Preferred Drug               |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| SPACE  | Not Covered (Space)          |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| Claims-Drug  | Drug Generic Name            | DRUG_GNRC_NM            | Alphanumeric | 80     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| Claims-Drug  | Drug Generic Product Code    | DRUG_GNRC_PRDCT_CD      | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| <table border="1"> <tr><td>0</td><td>Non-Drug Item</td></tr> <tr><td>1</td><td>Generic Drug</td></tr> <tr><td>2</td><td>Branded Drug</td></tr> <tr><td>3</td><td>Multi-Source Drug</td></tr> <tr><td>4</td><td>Single-Source Drug</td></tr> <tr><td>SPACE</td><td>Default</td></tr> </table>             |                              |                         |              |        |                          |                          |          |                          |                          | 0 | Non-Drug Item           | 1 | Generic Drug  | 2 | Branded Drug | 3 | Multi-Source Drug | 4     | Single-Source Drug  | SPACE | Default    |    |         |
| 0  | Non-Drug Item                |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 1  | Generic Drug                 |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 2  | Branded Drug                 |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 3  | Multi-Source Drug            |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 4  | Single-Source Drug           |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| SPACE  | Default                      |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| Claims-Drug  | Drug Generic Sources Code    | DRUG_REF_GNRC_SRCS_CD   | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| <table border="1"> <tr><td>1</td><td>Multiple Source</td></tr> <tr><td>2</td><td>Single Source</td></tr> </table>  |                              |                         |              |        |                          |                          |          |                          |                          | 1 | Multiple Source         | 2 | Single Source |   |              |   |                   |       |                     |       |            |    |         |
| 1  | Multiple Source              |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 2  | Single Source                |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| Claims-Drug  | Drug Name                    | DRUG_NM                 | Alphanumeric | 200    | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| Claims-Drug  | Drug Prescription Number     | CLM_RX_NBR              | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| Claims-Drug  | Drug Refill Code             | DRUG_RFL_CD             | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| <table border="1"> <tr><td>0</td><td>Original</td></tr> <tr><td>1</td><td>1st Refill</td></tr> <tr><td>2</td><td>2nd Refill</td></tr> <tr><td>3</td><td>3rd Refill</td></tr> <tr><td>4</td><td>4th Refill</td></tr> <tr><td>5</td><td>5th Refill</td></tr> <tr><td>99</td><td>Default</td></tr> </table> |                              |                         |              |        |                          |                          |          |                          |                          | 0 | Original                | 1 | 1st Refill    | 2 | 2nd Refill   | 3 | 3rd Refill        | 4     | 4th Refill          | 5     | 5th Refill | 99 | Default |
| 0  | Original                     |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 1  | 1st Refill                   |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 2  | 2nd Refill                   |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 3  | 3rd Refill                   |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 4  | 4th Refill                   |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 5  | 5th Refill                   |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| 99   | Default                      |                         |              |        |                          |                          |          |                          |                          |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |
| Claims-Drug  | Drug Schedule Code           | DEA_SCHED_CD            | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |   |                         |   |               |   |              |   |                   |       |                     |       |            |    |         |

**Fields: Sheps Center Medicaid data**

| Category    | Field                                   | Field - Literal              | Format       | Length | Institutional            | Professional             | Pharmacy | Dental                   | CapMgmt                  |
|-------------|---|------------------------------|--------------|--------|--------------------------|--------------------------|----------|--------------------------|--------------------------|
| Claims-Drug | Drug Sequence Number                    | DRUG_REF_GNRC_CNTL_SEQ_NBR   | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Drug | Drug Strength                           | DRUG_STRNGT_DESC             | Alphanumeric | 200    | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Drug | Drug Therapeutic Class Code             | DRUG_REF_THRPTC_CLS_SPCFC_CD | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Drug | Drug Therapeutic Class Code Description | SPEC_THERA_DESC              | Alphanumeric | 100    | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Drug | National Drug Code                      | DRUG_CD                      | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Drug | NCPDP Compound Drug Code                | NCPDP_CMPND_DRUG_CD          | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |
|             | 1                                       | Not Compound                 |              |        |                          |                          |          |                          |                          |
|             | 2                                       | Compound                     |              |        |                          |                          |          |                          |                          |
| Claims-Drug | Paid Quantity Count (Drug)              | DRUG_PD_QTY_CT               | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | Y        | <input type="checkbox"/> | <input type="checkbox"/> |

Fields: Sheps Center Medicaid data

| Category   | Field                                     | Field - Literal         | Format       | Length | Institutional            | Professional             | Pharmacy                 | Dental                   | CapMgmt                  |                   |   |                  |  |  |  |  |  |
|--|---|-------------------------|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------|---|------------------|--|--|--|--|--|
| Claims-Financial   | Claim Base Amount Source Code             | RATE_TYPE               | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Claim Base Amount Source Code Description | RATE_TYPE_DESC          | Alphanumeric | 200    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Claim Header Allowed Amount               | TTL_ALLW_AMT            | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Claim Line Allowed Amount                 | LNE_ALLW_CHRG_AMT       | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Claim Line Allowed Ingredient Cost Amount | LNE_ALLW_INGRD_AMT      | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Claim Line Copay Amount                   | LINEDE_LNE_COPAY_AMT    | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Claim Line Copay Amount                   | LNEPR_LNE_COPAY_AMT     | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Claim Line Copay Amount                   | LNEIN_LNE_COPAY_AMT     | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Claim Line Preliminary Allowed Amount     | CLM_LNE_PRLMNR_ALLW_AMT | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Credit Code                               | CR_CD                   | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | DRG DME Amount                            | LNE_DRG_DIR_AMT         | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | DRG IME Amount                            | LNE_DRG_INDIR_AMT       | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Gross Amount due                          | GRS_DUE_AMT             | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Header Transaction Type Code              | HDR_TRNSCT_TYP_CD       | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| <table border="1"> <tbody> <tr> <td>0</td> <td>Original Claim</td> </tr> <tr> <td>1</td> <td>Void/Credit</td> </tr> <tr> <td>2</td> <td>Adjustment Credit</td> </tr> <tr> <td>3</td> <td>Adjustment Debit</td> </tr> </tbody> </table> |   |                         |              |        | 0                        | Original Claim           | 1                        | Void/Credit              | 2                        | Adjustment Credit | 3 | Adjustment Debit |  |  |  |  |  |
| 0  | Original Claim                            |                         |              |        |                          |                          |                          |                          |                          |                   |   |                  |  |  |  |  |  |
| 1  | Void/Credit                               |                         |              |        |                          |                          |                          |                          |                          |                   |   |                  |  |  |  |  |  |
| 2  | Adjustment Credit                         |                         |              |        |                          |                          |                          |                          |                          |                   |   |                  |  |  |  |  |  |
| 3  | Adjustment Debit                          |                         |              |        |                          |                          |                          |                          |                          |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Line Allowed Units                        | LNE_ALLW_UNT_NBR        | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Line Reimbursement Amount                 | LNE_RMBRS_AMT           | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Line Submit Charge Amount                 | LNE_SBMT_CHRG_AMT       | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Net Payment                               | LNE_NET_PAY_AMT         | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Payer ID                                  | PYR_REF_ID              | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Replaced Transaction Control Number       | RPLCD_TRNSCT_CNTL_NBR   | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Replacement Transaction Control Number    | RPLCM_TRNSCT_CNTL_NBR   | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Revenue Code                              | RVN_CD                  | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Revenue Code Description                  | REV_DESC                | Alphanumeric | 40     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |
| Claims-Financial   | Third Party Liability Amount              | LNE_TPL_AMT             | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                   |   |                  |  |  |  |  |  |

**Fields: Sheps Center Medicaid data**

| Category         | Field                                | Field - Literal             | Format       | Length | Institutional            | Professional             | Pharmacy                 | Dental                   | CapMgmt                  |
|------------------|--------------------------------------|-----------------------------|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Claims-Financial | Total Allowed Ingredient Cost Amount | TTL_ALLW INGRD_AMT          | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | Y                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Financial | Total Amount Paid                    | TTL_NET_PAY_AMT             | Numeric      | 8      | Y                        | Y                        | Y                        | Y                        | Y                        |
| Claims-Financial | Total Billed or Charged Amount       | TTL_CHRG_AMT                | Numeric      | 8      | Y                        | Y                        | Y                        | Y                        | Y                        |
| Claims-Financial | Total Calculated Allowed Amount      | TTL_CLM_CALC CD_ALLOWED_AMT | Numeric      | 8      | Y                        | Y                        | Y                        | Y                        | Y                        |
| Claims-Financial | Total DRG DME Amount                 | TTL_DRG_DIR_AMT             | Numeric      | 8      | Y                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Financial | Total DRG IME Amount                 | TTL_DRG_INDIR_AMT           | Numeric      | 8      | Y                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Financial | Total Drug Paid Amount               | TTL_DRUG_PD_AMT             | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | Y                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Financial | Total Reimbursed Amount              | TTL_RMBRSD_AMT              | Numeric      | 8      | Y                        | Y                        | Y                        | Y                        | Y                        |
| Claims-Financial | Total Third Party Liability Amount   | HDR_TTL_TPL_AMT             | Numeric      | 8      | Y                        | Y                        | Y                        | Y                        | Y                        |
| Claims-Financial | Total Third Party Liability Amount   | HDRPR_TTL_TPL_AMT           | Numeric      | 8      | <input type="checkbox"/> | Y                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Financial | Total Third Party Liability Amount   | HDRDENTAL_TTL_TPL_AMT       | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Y                        | <input type="checkbox"/> |
| Claims-Financial | Total Third Party Liability Amount   | HDRIN_TTL_TPL_AMT           | Numeric      | 8      | Y                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Financial | Total Third Party Liability Amount   | HDRRX_TTL_TPL_AMT           | Numeric      | 8      | <input type="checkbox"/> | Y                        | Y                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Financial | Transaction Control Number           | TRNSCT_CNTL_NBR             | Alphanumeric | 30     | Y                        | Y                        | Y                        | Y                        | Y                        |



**Fields: Sheps Center Medicaid data**

| Category         | Field                           | Field - Literal   | Format       | Length | Institutional | Professional | Pharmacy | Dental | CapMgmt |
|------------------|---------------------------------|---|--------------|--------|---------------|--------------|----------|--------|---------|
| Claims-Financial | Type of Bill Facility Type Code | TYP_OF_BILL_DIGITS_1_AND_2_CD                             | Alphanumeric | 20     | Y             |              |          |        |         |
|                  | 11                              | Hospital Inpatient (Including Medicare Part A)            |              |        |               |              |          |        |         |
|                  | 12                              | Hospital Inpatient (Medicare Part B Only)                 |              |        |               |              |          |        |         |
|                  | 13                              | Hospital Outpatient                                       |              |        |               |              |          |        |         |
|                  | 14                              | Hospital - Lab Services Provided To Non-Patients          |              |        |               |              |          |        |         |
|                  | 18                              | Hospital - Swing Beds                                     |              |        |               |              |          |        |         |
|                  | 21                              | Skilled Nursing - Inpatient (Incl Medicare Part A)        |              |        |               |              |          |        |         |
|                  | 22                              | Skilled Nursing - Inpatient (Medicare Part B Only)        |              |        |               |              |          |        |         |
|                  | 23                              | Skilled Nursing - Outpatient                              |              |        |               |              |          |        |         |
|                  | 28                              | Skilled Nursing - Swing Beds                              |              |        |               |              |          |        |         |
|                  | 32                              | Home Health - Inpat (Plan Of Tret Part B Only)            |              |        |               |              |          |        |         |
|                  | 33                              | Home Health - Outpt (Plan Of Tret Part A, Inc Dme)        |              |        |               |              |          |        |         |
|                  | 34                              | Home Health - Other (For Med/Surg Serv No Plan)           |              |        |               |              |          |        |         |
|                  | 41                              | Religious Non-Med Health Care Institu - Hosp Inp          |              |        |               |              |          |        |         |
|                  | 43                              | Religious Non-Medical Health Care Institu - Outpat        |              |        |               |              |          |        |         |
|                  | 65                              | Intermediate Care - Level I                               |              |        |               |              |          |        |         |
|                  | 66                              | Intermediate Care - Level II                              |              |        |               |              |          |        |         |
|                  | 71                              | Clinic - Rural Health                                     |              |        |               |              |          |        |         |
|                  | 72                              | Clinic - Hosp Based Or Ind Renal Dialysis Center          |              |        |               |              |          |        |         |
|                  | 73                              | Clinic - Freestanding                                     |              |        |               |              |          |        |         |
|                  | 74                              | Clinic - Outpatient Rehabilitation Facility (ORF)         |              |        |               |              |          |        |         |
|                  | 75                              | Clinic - Comprehensive Outpat Reh Facility (CORF)         |              |        |               |              |          |        |         |
|                  | 76                              | Clinic - Community Mental Health Center                   |              |        |               |              |          |        |         |
|                  | 77                              | Clinic - Fed Qualified Health Cent (FQHC 04/01/10)        |              |        |               |              |          |        |         |
|                  | 78                              | Licensed Freestanding Emergency Medical Facility (7/2012) |              |        |               |              |          |        |         |
|                  | 79                              | Clinic-Other  |              |        |               |              |          |        |         |
|                  | 81                              | Special Facility - Hospice (Non-Hospital Based)           |              |        |               |              |          |        |         |
|                  | 82                              | Special Facility - Hospice (Hospital Based)               |              |        |               |              |          |        |         |
|                  | 83                              | Special Facility - Ambulatory Surgery Center              |              |        |               |              |          |        |         |
|                  | 84                              | Special Facility - Free Standing Birthing Center          |              |        |               |              |          |        |         |
|                  | 85                              | Special Facility - Critical Access Hospital               |              |        |               |              |          |        |         |
|                  | 86                              | Special Facility - Residential Facility                   |              |        |               |              |          |        |         |
|                  | 89                              | Special Facility - Other                                  |              |        |               |              |          |        |         |

Fields: Sheps Center Medicaid data

| Category         | Field                       | Field - Literal   | Format       | Length | Institutional | Professional | Pharmacy | Dental | CapMgmt |
|------------------|-----------------------------|---|--------------|--------|---------------|--------------|----------|--------|---------|
| Claims-Financial | Type of Bill Frequency Code | TYP_OF_BILL_DIGIT_3_CD  | Alphanumeric | 20     | Y             |              |          |        |         |
|                  | 0                           | Non-Payment/Zero Claim  |              |        |               |              |          |        |         |
|                  | 1                           | Admit Thru Discharge Claim  |              |        |               |              |          |        |         |
|                  | 2                           | Interim - First Claim   |              |        |               |              |          |        |         |
|                  | 3                           | Interim - Continuing Claim  |              |        |               |              |          |        |         |
|                  | 4                           | Interim - Last Claim  |              |        |               |              |          |        |         |
|                  | 5                           | Late Charges Only   |              |        |               |              |          |        |         |
|                  | 6                           | Reserved By NUBC6   |              |        |               |              |          |        |         |
|                  | 7                           | Replacement Of Prior Claim  |              |        |               |              |          |        |         |
|                  | 8                           | Void/Cancel Of Prior Claim  |              |        |               |              |          |        |         |
|                  | 9                           | Final Claim For A Home Health PPS Episode                         |              |        |               |              |          |        |         |
|                  | A                           | Admission/Election Notice   |              |        |               |              |          |        |         |
|                  | B                           | Notice Of Termination/Revocation Of Hospice, CMS Coordinated Care |              |        |               |              |          |        |         |
|                  | C                           | Notice Of Change To Hospice Provider                              |              |        |               |              |          |        |         |
|                  | D                           | Notice Of Void  |              |        |               |              |          |        |         |
|                  | E                           | Notice Of Change Of Ownership For Hospice                         |              |        |               |              |          |        |         |
|                  | F                           | Recipient Initated Adjustment Claim                               |              |        |               |              |          |        |         |
|                  | G                           | Common Working File Initiated Adjustment                          |              |        |               |              |          |        |         |
|                  | H                           | CMS Initated Adjustment Claim                                     |              |        |               |              |          |        |         |
|                  | I                           | Intermediary Adjustment Claim                                     |              |        |               |              |          |        |         |
|                  | J                           | Initiated Adjustment Claim - Other                                |              |        |               |              |          |        |         |
|                  | K                           | OIG Initiated Adjustment  |              |        |               |              |          |        |         |
|                  | L                           | Reserved For NUBCL  |              |        |               |              |          |        |         |
|                  | M                           | Medicare Secondary Payer Initiated Adjustment                     |              |        |               |              |          |        |         |
|                  | N                           | Reserved For NUBCN  |              |        |               |              |          |        |         |
|                  | O                           | Non-Payment/Zero Claim O  |              |        |               |              |          |        |         |
|                  | P                           | QIO Adjustment Claim  |              |        |               |              |          |        |         |
|                  | Q                           | Not To Be Used By Providers                                       |              |        |               |              |          |        |         |
|                  | R                           | Reserved For NUBCR  |              |        |               |              |          |        |         |
|                  | S                           | Reserved For NUBCS  |              |        |               |              |          |        |         |
|                  | T                           | Reserved For NUBCT  |              |        |               |              |          |        |         |
|                  | U                           | Reserved For NUBCU  |              |        |               |              |          |        |         |

**Fields: Sheps Center Medicaid data**

| Category         | Field      | Field - Literal  | Format  | Length | Institutional            | Professional             | Pharmacy                 | Dental                   | CapMgmt                  |
|------------------|------------|--|---------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                  | V          | Reserved For NUBCV   |         |        |                          |                          |                          |                          |                          |
|                  | W          | Reserved For NUBCW   |         |        |                          |                          |                          |                          |                          |
|                  | X          | Used By Medicare Advantage To Void Incorrect Previous Encounter    |         |        |                          |                          |                          |                          |                          |
|                  | Y          | Used By Medicare Advantage To Replace Previous Submitted Encounter |         |        |                          |                          |                          |                          |                          |
|                  | Z          | Used By Medicare Advantage To Submit New Encounter Data            |         |        |                          |                          |                          |                          |                          |
| Claims-Financial | Units Paid | LNE_RMBRS_UNT_NBR  | Numeric | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Fields: Sheps Center Medicaid data

| Category     | Field                    | Field - Literal    | Format       | Length | Institutional | Professional | Pharmacy | Dental | CapMgmt |
|--------------|--------------------------|--------------------|--------------|--------|---------------|--------------|----------|--------|---------|
| Claims-Other | Aid Category Code        | MBR_AID_CTG_CD     | Alphanumeric | 20     | Y             | Y            | Y        | Y      | Y       |
|              | AA                       | Elig-Aid-Aged      |              |        |               |              |          |        |         |
|              | AB                       | Elig-Aid-Blind     |              |        |               |              |          |        |         |
|              | AD                       | Elig-Aid-Disabled  |              |        |               |              |          |        |         |
|              | AF                       | Elig-Aid-FDC       |              |        |               |              |          |        |         |
|              | AG                       | Elig-Adopt-Grand   |              |        |               |              |          |        |         |
|              | AS                       | Elig-Adopt-Subsidy |              |        |               |              |          |        |         |
|              | CD                       | Elig-Certain-Disab |              |        |               |              |          |        |         |
|              | CF                       | Elig-Certain-FC    |              |        |               |              |          |        |         |
|              | FC                       | Elig-Foster-Care   |              |        |               |              |          |        |         |
|              | IC                       | Elig-Inf-Child     |              |        |               |              |          |        |         |
|              | NA                       | Not Applicable     |              |        |               |              |          |        |         |
|              | PW                       | Elig-Preg-Women    |              |        |               |              |          |        |         |
|              | QB                       | Elig-Catastophic   |              |        |               |              |          |        |         |
|              | RC                       | Elig-Reason-Class  |              |        |               |              |          |        |         |
|              | RF                       | Elig-Aid-Refugee   |              |        |               |              |          |        |         |
|              | SB                       | Elig-Sa-Blind      |              |        |               |              |          |        |         |
|              | SF                       | Elig-Aid-SFHF      |              |        |               |              |          |        |         |
| Claims-Other | Aid Category Description | MBR_AID_CTG_DESC   | Alphanumeric | 200    | Y             |              | Y        | Y      | Y       |
| Claims-Other | Aid Category Description | MBR_AID_CTG_DES    | Alphanumeric | 200    |               | Y            |          |        |         |
| Claims-Other | Aid Program Code         | MBR_AID_PGM_CD     | Alphanumeric | 20     | Y             | Y            | Y        | Y      | Y       |
| Claims-Other | Aid Program Description  | MBR_AID_PGM_DESC   | Alphanumeric | 200    | Y             | Y            | Y        | Y      | Y       |
| Claims-Other | Benefit Plan             | BNFTPLN_ID         | Numeric      | 8      | Y             | Y            | Y        | Y      | Y       |
| Claims-Other | Benefit Plan Description | MBR_BNFTPLN_DESC   | Alphanumeric | 200    | Y             | Y            | Y        | Y      |         |

**Fields: Sheps Center Medicaid data**

| Category     | Field           | Field - Literal                                   | Format       | Length | Institutional | Professional | Pharmacy | Dental | CapMgmt |
|--------------|-----------------|---|--------------|--------|---------------|--------------|----------|--------|---------|
| Claims-Other | Claim Type Code | HDR_TYP_CD  | Alphanumeric | 20     | Y             | Y            | Y        | Y      | Y       |
|              | 0               | Local Education Agencies                          |              |        |               |              |          |        |         |
|              | 1               | Home Infusion Therapy                             |              |        |               |              |          |        |         |
|              | 2               | Therapy Services                                  |              |        |               |              |          |        |         |
|              | 3               | Institutional Ambulance                           |              |        |               |              |          |        |         |
|              | 4               | Capitation  |              |        |               |              |          |        |         |
|              | 5               | Rural Hlth Clinic / Federally Qualified Hlth Cntr |              |        |               |              |          |        |         |
|              | 6               | Personal Care Services                            |              |        |               |              |          |        |         |
|              | 8               | Indep Diag Testing Facility / Portable Xray       |              |        |               |              |          |        |         |
|              | A               | Medicare Part A Crossover (Inpatient)             |              |        |               |              |          |        |         |
|              | B               | Medicare Part B Crossover (Professional)          |              |        |               |              |          |        |         |
|              | C               | Health Departments                                |              |        |               |              |          |        |         |
|              | D               | Dental  |              |        |               |              |          |        |         |
|              | E               | Hearing Aid                                       |              |        |               |              |          |        |         |
|              | F               | Nursing Home                                      |              |        |               |              |          |        |         |
|              | G               | Hospice   |              |        |               |              |          |        |         |
|              | H               | Home Health                                       |              |        |               |              |          |        |         |
|              | I               | Inpatient   |              |        |               |              |          |        |         |
|              | K               | Private Duty Nursing                              |              |        |               |              |          |        |         |
|              | L               | Independent Laboratory / Xray                     |              |        |               |              |          |        |         |
|              | M               | Management Fee                                    |              |        |               |              |          |        |         |
|              | N               | Adult Care Homes                                  |              |        |               |              |          |        |         |
|              | O               | Outpatient  |              |        |               |              |          |        |         |
|              | P               | Professional                                      |              |        |               |              |          |        |         |
|              | Q               | Mental Health                                     |              |        |               |              |          |        |         |
|              | R               | Drug  |              |        |               |              |          |        |         |
|              | S               | Durable Medical Equipment                         |              |        |               |              |          |        |         |
|              | T               | Ambulance (Professional)                          |              |        |               |              |          |        |         |
|              | U               | Medicare Part B Crossover UB (Outpatient)         |              |        |               |              |          |        |         |
|              | V               | Childrens Developmental Services Agencies         |              |        |               |              |          |        |         |
|              | W               | Financial Claim                                   |              |        |               |              |          |        |         |
|              | X               | Optical   |              |        |               |              |          |        |         |
|              | Y               | Undefined Professional                            |              |        |               |              |          |        |         |

Fields: Sheps Center Medicaid data

| Category     | Field                           | Field - Literal         | Format       | Length | Institutional            | Professional             | Pharmacy                 | Dental                   | CapMgmt                  |
|--------------|---------------------------------|-------------------------|--------------|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|              | Z                               | Undefined Institutional |              |        |                          |                          |                          |                          |                          |
| Claims-Other | Header Ending Date of Service   | HDR_SVC_END_DT          | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Other | Header Starting Date of Service | HDR_SVC_BGN_DT          | Numeric      | 8      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Other | Header status code              | HDR_STAT_CD             | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Other | Line Status Code                | LNE_STAT_CD             | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Other | Member Relationship Code        | MBR_REF_REL_TO_PAY_CD   | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | A                               | Spouse                  |              |        |                          |                          |                          |                          |                          |
|              | B                               | Son                     |              |        |                          |                          |                          |                          |                          |
|              | C                               | Daughter                |              |        |                          |                          |                          |                          |                          |
|              | D                               | Stepson                 |              |        |                          |                          |                          |                          |                          |
|              | E                               | Stepdaughter            |              |        |                          |                          |                          |                          |                          |
|              | F                               | Mother                  |              |        |                          |                          |                          |                          |                          |
|              | G                               | Father                  |              |        |                          |                          |                          |                          |                          |
|              | H                               | Mother In Law           |              |        |                          |                          |                          |                          |                          |
|              | I                               | Father In Law           |              |        |                          |                          |                          |                          |                          |
|              | J                               | Grand Child             |              |        |                          |                          |                          |                          |                          |
|              | K                               | Student                 |              |        |                          |                          |                          |                          |                          |
|              | L                               | Self                    |              |        |                          |                          |                          |                          |                          |
|              | M                               | Brother                 |              |        |                          |                          |                          |                          |                          |
|              | N                               | Sister                  |              |        |                          |                          |                          |                          |                          |
|              | O                               | Nephew                  |              |        |                          |                          |                          |                          |                          |
|              | P                               | Niece                   |              |        |                          |                          |                          |                          |                          |
|              | Q                               | Foster Child            |              |        |                          |                          |                          |                          |                          |
|              | R                               | Child                   |              |        |                          |                          |                          |                          |                          |
| Claims-Other | Patient Status Code             | PAT_STAT_CD             | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Other | Place of Service Code           | POS_CD                  | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Other | Primary Care Physician ID       | MBR_REF_PCP_ID          | Alphanumeric | 30     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Other | Prior Approval Type Code        | PRI_APRV_REF_TYP_CD     | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Claims-Other | Prior Authorization Number      | PRI_APRV_NBR            | Alphanumeric | 20     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Fields: Sheps Center Medicaid data

| Category     | Field   | Field - Literal                                  | Format       | Length | Institutional                       | Professional                        | Pharmacy                            | Dental                              | CapMgmt                             |
|--------------|---|--|--------------|--------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Claims-Other | Special Coverage Code                             | MBR_REF_SPCL_CVRG_CD                             | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|              | AI  | AI-CAP/AIDS ICF-Obsolete 12/31/06                |              |        |                                     |                                     |                                     |                                     |                                     |
|              | AS  | AS-CAP/AIDS SNF-Obsolete 12/31/06                |              |        |                                     |                                     |                                     |                                     |                                     |
|              | BH  | Traumatic Brain Injury - Specialty Hospital      |              |        |                                     |                                     |                                     |                                     |                                     |
|              | BN  | Traumatic Brain Injury - Nursing Facility        |              |        |                                     |                                     |                                     |                                     |                                     |
|              | C2  | C2-CAP-MR/DD ICF MR Level Of Care Eff 11/01/08   |              |        |                                     |                                     |                                     |                                     |                                     |
|              | CC  | CC-CAP/Children-Prior To 11/01/95                |              |        |                                     |                                     |                                     |                                     |                                     |
|              | CI  | CI-CAP/DA ICF Level Of Care                      |              |        |                                     |                                     |                                     |                                     |                                     |
|              | CM  | CM-CAP-MR/DD ICF MR Level Of Care                |              |        |                                     |                                     |                                     |                                     |                                     |
|              | CS  | CS-CAP/DA SNF Level Of Care                      |              |        |                                     |                                     |                                     |                                     |                                     |
|              | HC  | HC-CAP/Children Hospital-Eff.11/01/95            |              |        |                                     |                                     |                                     |                                     |                                     |
|              | IC  | IC-CAP/Children ICF-Effective 11/01/95           |              |        |                                     |                                     |                                     |                                     |                                     |
|              | ID  | ID-CAP Choice ICF                                |              |        |                                     |                                     |                                     |                                     |                                     |
|              | IN  | Innovations                                      |              |        |                                     |                                     |                                     |                                     |                                     |
|              | LT  | Spl Assist-Cases Awaiting A Higher Level Of Care |              |        |                                     |                                     |                                     |                                     |                                     |
|              | SC  | SC-CAP/Children SNF-Effective 11/01/95           |              |        |                                     |                                     |                                     |                                     |                                     |
|              | SD  | SD-CAP Choice SNF                                |              |        |                                     |                                     |                                     |                                     |                                     |
| Claims-Other | Specifies the classification of claims in a batch | CLM_BTCH_DOC_TYP_CD                              | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|              | C   | Original Claim                                   |              |        |                                     |                                     |                                     |                                     |                                     |
|              | E   | Encounter  |              |        |                                     |                                     |                                     |                                     |                                     |
|              | W   | Web Service Transaction                          |              |        |                                     |                                     |                                     |                                     |                                     |
| Claims-Other | Type of Service Code                              | CHI_SVC_AUTH_SA_TYP_SVC_CD                       | Alphanumeric | 20     | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Claims-Other | Type of Service Code                              | NCPDP_LVL_OF_SVC                                 | Alphanumeric | 20     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
|              | 0   | Not Specified                                    |              |        |                                     |                                     |                                     |                                     |                                     |
|              | 1   | Patient Consultation                             |              |        |                                     |                                     |                                     |                                     |                                     |
|              | 2   | Home Delivery                                    |              |        |                                     |                                     |                                     |                                     |                                     |
|              | 3   | Emergency  |              |        |                                     |                                     |                                     |                                     |                                     |
|              | 4   | 24 Hour Service                                  |              |        |                                     |                                     |                                     |                                     |                                     |
|              | 5   | Patient Consultation Regarding Generic Selection |              |        |                                     |                                     |                                     |                                     |                                     |
|              | 6   | In-Home Service                                  |              |        |                                     |                                     |                                     |                                     |                                     |
| Claims-Other | Type of Service Code                              | CHD_SVC_AUTH_SA_TYP_SVC_CD                       | Alphanumeric | 20     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Claims-Other | Type of Service Code                              | CHP_SVC_AUTH_SA_TYP_SVC_CD                       | Alphanumeric | 20     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |