SAMPLE

Provider Name																								
Provider Number (6 Digit)																								
Provider Point of Contact (POC) Name																								
POC Telephone Number																								
POC Email																								
Submission Date																								
Provider State																								
MAC Name								Columns H-Y will be populated by the MAC at effectuation															
NPI	DCN Claim Number	ALJ Appeal Number	DAB Docket Number	Date of Admission	Status Code	Reason Code	CMS Medicare Review Contractor who issued intial denial	Original Inpatient Claim Paid Amount (PostPay) or Payable Amount (Prepay--e.g. Pricer Amount)	Collected Amount	CMS Net Settlement Amount	AR - Principal	AR - Interest	Principal Collected (Offset)	Interest Collected (Offset)	Principal Collected (Receipt)	Interest Collected (Receipt)	Total Principal Collected	Total Interest Collected	Principal Adjustment	Interest Adjustment	Pre-Pay Denial Payments Due Provider (Remit PLB CS)	Post Pay Denial Amounts Due Medicare (Overpayment)	Post Pay Denial Refunds Due Provider (Remit PLB 72)	Net Payment/Overpayment Amount (Positive= Payment/Negative=Overpayment)