DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
7500 Security Boulevard, Mail Stop C1-05-17
Baltimore, Maryland 21244-1850

Medicare Plan Accountability Group

DATE: September 20, 2005

TO: All Medicare Advantage (MA) Plans, Part D Plans (PDPs), Cost-Based Organizations and Demonstrations

FROM: Cynthia E. Moreno
Acting Director

SUBJECT: 2006 Medicare Advantage and Part D Enrollment and Payment Systems Changes Part IV --Action

The purpose of this letter is to provide additional technical information to the plans regarding the following items:

- The final version of the Plan payment report,
- Clarification regarding transaction type 72 processing
- Accessing CMS systems for eligibility verification,
- Cost plan transaction processing,
- Reporting RXID/RXGROUP/RXBIN/RXPCN data,
- Reporting Coordination of Benefits (COB) data,
- Submitting Banking Information,
- Auto-enrollment Items: Cost Plan Clarification and accessing the MA-PD/Cost plan Full Dual file (Sept and Oct versions) and
- Delays in Railroad Retirement Board (RRB) and Office of Personnel Management (OPM) Processing of Premium Withhold Transactions.

In addition to the above items, we are re-issuing the MMA enrollment/disenrollment/PBP change/Plan change transaction layouts (that were initially provided in the May 31, 2005 systems letter) to confirm that the RXID and RXGROUP fields have been removed (the fields are now filler) and to provide better notes regarding the field definitions (Attachment A).

Please note that these versions of the MMA enrollment/disenrollment/PBP change/Plan change transaction layouts must be used to submit data to MARX. This is true whether the transaction contains an effective date in 2005 or 2006. Also, the new versions of the transaction reply (TRR) and monthly membership (MMR) reports will be created by MARX. The new transactions cannot be used to submit data to MMCS nor will the new versions of the reports be created by MMCS.

Currently MARX implementation is scheduled for October 24. That would mean that plans would use the new versions of the MMA transactions and would receive the new versions of the TRR and MMR effective with the December 2005 payment. However,

CMS is considering delaying MARX implementation until November 23 to provide more time for user testing. You will be notified within one week of the release of this letter of the confirmed MARX implementation date.

Please note that, for Part D enrollments submitted for effective dates prior to August 2006 (when the late enrollment penalty will be applicable); that a Y must be in the Creditable Coverage field and a zero in the Noncovered Months field.

In this letter, we are also re-issuing the Ongoing Auto and Facilitated Enrollment Address File (Attachment B) and the One-Time PDP Auto-Assignment File (Attachment C) to correct the low-income co-payment field values. The latter file also includes expanded Name fields. These layouts are all now considered to be final.

Plan Payment Report (PPR) - Final

The PPR will be expanded to include Part D payments and adjustments, the National Medicare Education Campaign (NMEC) and Coordination of Benefits (COB) User Fees and premium settlement information. There will be one version of the PPR applicable to all plans and it will be provided monthly. See Attachment D for the record layout.

The revised version of this report will be effective with the January payments.

The PPR will contain payment data in a similar manner as the schedule provided in the July 5, 2005 systems letter related to the Monthly Premium Withholding Report. We have repeated it here for your convenience.

PAYMENT #	PAYMENT DATE	PAYMENT CONTAINS….	PPR CONTAINS….
1	January 1, 2006	January Part D capitated and LIS payments from CMS	January Part D capitated and LIS payments from CMS
2	February 1, 2006	February Part D capitated and LIS payments from CMS + January Withheld premiums from SSA, RRB & OPM	February Part D capitated and LIS payments from CMS + January Withheld premiums from SSA, RRB & OPM
3	March 1, 2006	March Part D capitated and LIS payments from CMS + February Withheld premiums from SSA, RRB & OPM	March Part D capitated and LIS payments from CMS + February Withheld premiums from SSA, RRB & OPM
4	April 1, 2006	April Part D capitated and LIS payments from CMS + March Withheld premiums from SSA, RRB & OPM	April Part D capitated and LIS payments from CMS + March Withheld premiums from SSA, RRB & OPM

The PPR will display the summarized amounts that constitute the monthly amount wired to you by the Treasury Department. This includes the Part A/B and D payment amounts. Some of the adjustments will have Part A/B and D components and there will also be 5 adjustment types related just to Part D.

The User Fees will be applied as follows during January through September of each year.

- The NMEC user fee will be applied against (1) MA-PD payments at 0.058% and (2) PDP payments at 0.051%.
- The COB user fee will be applied against members electing Part D at $.11 for January – August and at $.12 for September.

The PPR will also include low-income premium subsidy payments made to you on behalf of your eligible members as well as the withheld premium amounts.

NOTE: The PPR will contain the summarized LIS amounts paid to you monthly. We understand this will be problematic if not shown at the beneficiary-level. So CMS is attempting to provide a monthly beneficiary-level LIS report as soon as possible. This report was described in the July 5, 2005 systems letter, Attachment F. If this is not available for the January 1, 2006 payment, these amounts can be derived from the MMR as follows.

- Identify all members that have a low-income cost sharing payment component
- Obtain the difference between the Total Part D Payment (field 71) and the sum of the Direct Subsidy (field 68) + the Reinsurance amount (field 69) + Low-Income Cost Sharing amount (field 70) + the Rebate for Part D Basic Premium Reduction (field 66).

This difference is the Low-Income Premium subsidy for the member.

Processing Transaction Type 72

Plans are to use the 72 Change transaction to report updates to previously provided information or to report premium-related information for existing members. Every effort should be made to only report the contract/plan benefit package numbers, beneficiary identifying information and any other fields that are changing or that need to be updated in CMS's systems. Plans should be aware that if they populate fields that do not represent changes, they will receive transaction replies for all of these fields. As MARX processes each field, a transaction reply will be generated. If plans wish to avoid supplemental transaction replies, they should only report data elements on a 72 transaction that need to be updated.

You were notified in the 2006 Call letter and in the May 31, 2005 systems letter to submit premium-related information for your current members. Based on feedback from many plans, we have reordered the priorities. The priority is to submit the 72 transactions for members that have elected the withhold option and for members you suspect may be LIS-eligible. This allows the premiums to be withheld more timely and avoids retroactive situations which may cause there to be insufficient funds. In addition, the only way to get LIS information on the TRR for current members is to submit a 72 transaction (unless they are changing their PBP; in these cases, a 71 transaction will be required).

CMS will provide guidance on the timeframe for submitting premium-related information for the remainder of your membership at a later date.

Accessing CMS Systems for Eligibility Verification
CMS will provide a Batch Eligibility Query (BEQ) to the Medicare Beneficiary Database (MBD) beginning 11/15/2005. See Attachment I for the request and the response file layouts and instructions. The batch request file must contain the HIC#, SSN, date of birth and gender code for each beneficiary to ensure that the proper identification is made. Plans may submit1BEQ request file per CMS business day; there is no limit to the number of detail records that can be included. CMS will process the request file and provide a response file containing Medicare entitlement dates, Medicaid indicator and employer subsidy information. If the request file cannot be processed, an e-mail will be sent to the sending entity identifying the condition that caused the rejection.

Cost Plan Transaction Processing
Because beneficiaries can choose to enroll in an outside PDP and remain in the cost plan, MARX will have to utilize PBP-level processing for your organizations. This will be accomplished by the following steps.

- HPMS will provide available drug and nondrug PBP numbers for Cost plans to MARX. If no nondrug PBPs were approved for the Cost plan, HPMS will generate a "dummy" nondrug PBP number of 999. This will not be necessary for drug PBPs as Cost plans were required to create drug PBPs.

- MARX will move all cost plan members to nondrug PBPs. This will be reported to you on the November and December MMRs.

As all members will begin in nondrug PBPs, Cost plans will submit transactions as follows.

- If a current member elects to obtain Part D through the Cost plan, submit a 71 transaction to move the member from the non-drug PBP to the drug PBP. Include the election type and Part D premium-related information.

- If a current member elects to obtain Part D through a PDP, the Cost plan submits no transactions. When the PDP submits a 61 transaction to enroll the beneficiary, MARX will not disenroll the member from the Cost plan.

- If a current member (who has been moved by you to a drug PBP) elects to drop Part D, but stay in the Cost plan, submit a 71 transaction to move the member from the drug PBP back to the non-drug PBP.

- If a current member (who has been moved by you to a drug PBP) elects to enroll in a PDP, you will receive a disenrollment due to enrollment in another plan (reply code – 014). When this occurs, contact the member to verify that they still want to be enrolled in the nondrug portion of the cost plan. You will submit a 61(with a nondrug PBP number) to re-enroll the member.

- If a new member elects to enroll in the nondrug portion of the cost plan, submit a 61 with a nondrug PBP number. (Use 999 if you do not have a nondrug PBP approved in HPMS.)

- If a new member elects to enroll in the drug portion of the cost plan, submit a 61 with the drug PBP number, election type and Part D premium-related information.

The following clarifications related to election periods will also impact cost plans. In 2 of the 3 scenarios below, an election type must be specified by you.

- Enrollment into a cost plan's nondrug PBP from FFS or a non MA plan does not require that an election type be specified. The beneficiary does not utilize an election when enrolling in non MA or non Part D plans.

- Enrollment into a Cost plan's non-drug PBP requires an election type to be specified if the member is currently enrolled in a MA, MA-PD, or PDP. This is because the beneficiary must utilize an election to disenroll from the latter plan types. At the time of enrollment, the Cost plan may need to query the beneficiary if they are currently enrolled in a Medicare Advantage or Part D plan.

- Enrollment into, or disenrollment from, a Cost plan's drug PBP requires an election type of AEP, IEP, or SEP to be specified. The beneficiary utilizes an election in these situations.

Reporting RXID/RXGROUP/RXPCN/RXBIN Data
After Plans receive confirmation that an individual has been enrolled, they will report the four RX data elements via the record layouts in Attachment E. Files can be submitted daily with no limit to the number of detail records included. Plans will provide beneficiary identifying information and the RXBin, RX PCN, RX ID and RX Group numbers. CMS will provide response files containing accept/reject codes as soon as the data has been processed.

Remember, you are only to submit this RX data for current members. This file format replaces the initial requirement to provide your RXID and RXGROUP numbers on the enrollment transactions.

Reporting Coordination of Benefits (COB) Data
CMS will provide COB information for your enrollees via the record layouts in Attachment F. This file can be provided as often as daily; but it will contain only members for which there is COB information available. For each member on the file, there can be multiple records associated with primary and supplemental insurers. Attachment F also defines the order of the records in the file.

Submitting Banking Information
New plans should submit their banking information to CMS on the form provided in the application. We have included it in Attachment H. These forms will only be processed for

approved plans. This information is needed to allow payments to be wired to your accounts each month.

Please complete the forms, have them signed by your financial manager and fax them to:

Dawn Arnold/Yvonne Rice
410.786.0322

Accessing the MA-PD/Cost Plan Full Dual File

CMS will provide MA organizations and cost plans a monthly file of their enrollees who are full-benefit dual eligibles, for purposes of facilitating their enrollment into the Medicare Part D benefit. CMS will make the file available on approximately the fifth of each month. The file will be sent monthly from September, 2005 through March, 2006. MA organizations and cost plans will retrieve the September and October files the way they current retrieve files from MMCS, i.e. off the mainframe. CMS will provide direction at a later date on how files from November through March will be made available.

The file name will be HKH.@BGD5050.PLNxxxxx.Rmmccyy.MMAADUA , where "xxxxx" will be the organization's five-character Contract ID number (i.e. starting with H, R, or 9, and followed by four numbers). The "Rmmccyy" will be the month/year of that file, e.g. R092005 for September 2005, R102005 for October 2005.

Please see the June 5, 2005 Systems letter, specifically pages 7-9 for how these data should be used, and page 32, Attachment I, for the file format (on our website at http://www.cms.hhs.gov/healthplans/letters/systemsletternumber3.pdf). Please note that MA organizations that will only offer MA-PD plans in 2006 will not need to use this file to auto-enroll, as all their enrollees, including full-benefit dual eligibles, will be transitioned to an MA-PD plan effective January 1, 2006. In addition, cost plans that will not offer a Part D optional supplemental benefit will not to use this file, as CMS will auto-enroll their full-benefit dual eligibles into stand-along Prescription Drug Plans (PDPs).

Cost Plan Auto-enrollment Clarification

CMS has directed cost plans that offer a Part D optional supplemental benefit to auto-enroll full-benefit dual eligibles into that benefit. Please see the July 7, 2005 Systems Letter for more detail (on our website at http://www.cms.hhs.gov/healthplans/letters/systemsletternumber3.pdf, see specifically pages 7-9).

When a cost plan auto-enrolls a current full-benefit dual eligible member to a drug PBP, submit a 71 transaction to move the member from the non-drug PBP to the drug PBP. Include the election type of "S" (Special Election Period) and Part D premium-related information.

If a full-benefit dual eligible current member (who has been auto-enrolled by you to a drug PBP) elects to affirmatively decline auto-enrollment into the drug PBP (i.e., drop Part D), but stay in the Cost plan, submit a 71 transaction to move the member from the drug PBP back to the non-drug PBP.

Delays in Railroad Retirement Board (RRB) and Office of Personnel Management (OPM) Processing Premium Withhold Transactions.

The RRB and the OPM will not be ready to process transactions for members that have elected the withhold option from their RRB/OPM benefits on January 2006. If beneficiaries want to elect these options, notify them that they are unavailable until further notice. If they insist, you may submit the transactions; the following will occur.

- RRB will return the transaction with a code notifying CMS that premiums cannot be withheld. RRB will send a letter to the beneficiary telling them that this option is not available. CMS will notify you on your transaction reply to directly bill the member.
- OPM will not accept the transaction and this will cause CMS to generate a transaction reply to you to directly bill the member.

We will notify you when RRB and OPM is ready to accept premium withhold transactions.

Contact Information

CMS is providing a technical customer support mechanism for all of our external customers. The Customer Support for Medicare Modernization (CSMM) will provide you with quality support for all of your connectivity needs, as well as aid in resolving technical application needs. The CSMM is currently available via a toll-free line, 1-800-927-8069, and email, mmahelp@cms.hhs.gov. In addition, a library of all plan/CMS files and transactions are located on this website.

If you have questions on the information contained in Attachment E (the RX file format) or Attachment I (the BEQ format), please contact Deb Stewart on 410.786.6151.

If you have questions on the information contained in Attachment F (the COB file format), please contact Harry Gamble on 410.786.5787.

If you have questions regarding Attachment H (Banking form), please contact Yvonne Rice on 410.786.7626.

If you have other questions regarding the material contained in this letter, please contact the central office staff person assigned to the area where your plan is located. See Attachment G.

ATTACHMENT A – MMA TRANSACTIONS
HEADER RECORD

ITEM	FIELDS	SIZE	POSITION	HEADER	DESCRIPTION
1	Header Message	12	1 – 12	R	'AAAAAAHEADER'
2	Filler	21	13 – 33	N/A	Spaces
3	Payment Month	6	34 – 39	R	MMYYYY (Note that the date should be one month after the processing date, e.g. input 022002 for data submitted before the January 2002 cutoff.)
4	Filler	185	40 – 224	N/A	Spaces

CORRECTION TRANSACTION (TYPE 01)

ITEM	FIELDS	SIZE	POSITION	REQUIREMENT	DESCRIPTION
1	HIC#	12	1 – 12	R	Nine-byte SSN of primary beneficiary (Beneficiary Claim Account Number); two-byte BIC (Beneficiary Identification Code); one-byte filler (except RRB)
2	Surname	12	13 – 24	R	Beneficiary Surname
3	First Name	7	25 – 31	R	Beneficiary Given Name
4	M. Initial	1	32		Beneficiary Middle Initial
5	Action Code	1	33	R	D = Institutional ON E = Medicaid ON F = Medicaid OFF G = Nursing Home Certifiable (NHC) ON
6	Filler	13	34 – 41	N/A	Spaces
10	Contract #	5	47 – 51	R	Contract Number
11	Filler	8	52 – 59	N/A	Spaces
12	Transaction Code	2	60 – 61	R	"01"
13	Filler	163	62 – 224	N/A	Spaces

ENROLLMENT/DISENROLLMENT/PBP CHANGE/PLAN CHANGE TRANSACTIONS

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (EMPLOYER & MCO) 60/61			DISENROLLMENT 51			PLAN ELECTION CHANGE) (PBP 71			PLAN CHANGE 72*		
				MA	MA-PD	PDP	MA	MA-PD	PDP	MA	MA-PD	PDP	MA	MA-PD	PDP
1	HIC#	12	1 – 12	R	R	R	R	R	R	R	R	R	R	R	R
2	Surname	12	13 – 24	R	R	R	R	R	R	R	R	R	R	R	R
3	First Name	7	25 – 31	R	R	R	R	R	R	R	R	R	R	R	R
4	M. Initial	1	32												
5	Sex	1	33	R	R	R	R	R	R	R	R	R	R	R	R
6	Birth Date (YYYYMMDD)	8	34 – 41	R	R	R	R	R	R	R	R	R	R	R	R
7	EGHP Flag	1	42	blank field has a meaning	blank field has a meaning	blank field has a meaning	N/A	N/A	N/A	blank field has a meaning	blank field has a meaning	blank field has a meaning	blank = no change	blank = no change	blank = no change
8	PBP #	3	43 – 45	R	R	R	N/A	N/A	N/A	R (Change-to value)	R (Change-to value)	R (Change-to value)	R	R	R
9	Election Type	1	46	R	R	R	R	R	R	R	R	R	R for premium withhold option changes; otherwise, N/A	R for premium withhold option changes; otherwise, N/A	R for premium withhold option changes; otherwise, N/A
10	Contract #	5	47 – 51	R	R	R	R	R	R	R	R	R	R	R	R
11	Application Date	8	52 – 59	R	R	R	N/A	N/A	N/A	R	R	R	N/A	N/A	N/A
12	Transaction Code	2	60 – 61	R	R	R	R	R	R	R	R	R	R	R	R

ENROLLMENT/DISENROLLMENT/PBP CHANGE/PLAN CHANGE TRANSACTIONS

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (EMPLOYER & MCO) 60/61			DISENROLLMENT 51			PLAN ELECTION CHANGE) (PBP 71			PLAN CHANGE 72*		
13	Disenrollment Reason (Future Use)	2	62 – 63	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14	Effective Date (YYYYMMDD)	8	64 – 71	R	R	R	R	R	R	R	R	R	R	R	R
15	Segment ID	3	72-74	R, blank for non-segmented organizations; otherwise, 3-digits	R, blank for non-segmented organizations; otherwise, 3-digits	N/A	N/A	N/A	N/A	R, blank for non-segmented organizations; otherwise, 3-digits	R, blank for non-segmented organizations; otherwise, 3-digits	N/A	Blank or change-to value for local plans; otherwise, N/A	Blank or change-to value for local plans; otherwise, N/A	N/A
16	Filler	5	75-79	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
17	Prior Commercial Override	1	80	If applies; otherwise, zero or blank	If applies; otherwise, zero or blank	N/A	N/A	N/A	N/A	If applies; otherwise, zero or blank	If applies; otherwise, zero or blank	N/A	N/A	N/A	N/A
18	Premium Withhold Option/ Parts C-D	1	81	R	R	R	N/A	N/A	N/A	R	R	R	blank or change-to value	blank or change-to value	blank or change-to value
19	Part C Premium Amount (XXXXvXX)	6	82 – 87	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value	N/A
20	Part D Premium Amount (XXXXvXX)	6	88 – 93	N/A	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value

ENROLLMENT/DISENROLLMENT/PBP CHANGE/PLAN CHANGE TRANSACTIONS

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (EMPLOYER & MCO) 60/61			DISENROLLMENT 51			PLAN ELECTION CHANGE) (PBP 71			PLAN CHANGE 72*		
21	Creditable Coverage Flag	1	94	N/A	R	R	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value
22	Number of Uncovered Months	3	95-97	N/A	R, blank = zero, meaning no uncovered months	R, blank = zero, meaning no uncovered months	N/A	N/A	N/A	N/A	R, blank = zero, meaning no uncovered months	R, blank = zero, meaning no uncovered months	N/A	Blank or change-to value	Blank or change-to value
23	Employer Subsidy Enrollment Override Flag	1	98	N/A	R if beneficiary has Employer Subsidy status; otherwise blank	R if beneficiary has Employer Subsidy status; otherwise blank	N/A	N/A	N/A	N/A	R if beneficiary has Employer Subsidy status; otherwise blank	R if beneficiary has Employer Subsidy status; otherwise blank	N/A	N/A	N/A
24	Part D Opt-Out Flag	1	99	N/A	N/A	N/A	N/A	R for auto-enrollees only; otherwise, N/A	R for auto-enrollees only; otherwise, N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	Filler	20	100-119	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
26	Filler	15	120-134	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	Secondary Drug Insurance Flag	1	135	N/A	R (Blank if auto-enroll)	R (Blank if auto-enroll)	N/A	N/A	N/A	N/A	R	R	N/A	Blank or change-to value	Blank or change-to value

ENROLLMENT/DISENROLLMENT/PBP CHANGE/PLAN CHANGE TRANSACTIONS

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (EMPLOYER & MCO) 60/61			DISENROLLMENT 51			PLAN ELECTION CHANGE) (PBP 71			PLAN CHANGE 72*		
28	Secondary Rx ID	20	136-155	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	N/A	N/A	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	R if secondary insurance change-to value is Y	R if secondary insurance change-to value is Y
29	Secondary Rx Group	15	156-170	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	N/A	N/A	N/A	R if secondary insurance; otherwise, N/A	R if secondary insurance; otherwise, N/A	N/A	R if secondary insurance change-to value is Y	R if secondary insurance change-to value is Y
30	Enrollment Source	1	171	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER	FILLER
31	SSN	9	172-180	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	FILLER	FILLER	FILLER
32	Trustee Routing Number	9	181-189	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	Blank or change-to value	FILLER	FILLER
33	Bank Account Number	17	190-206	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	Blank or change-to value	FILLER	FILLER
34	Bank Account Type	1	207	R (MSA ONLY)	FILLER	FILLER	N/A	FILLER	FILLER	R (If change to MSA)	FILLER	FILLER	Blank or change-to value	FILLER	FILLER
35	Filler	17	208-224	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

ENROLLMENT/DISENROLLMENT/PBP CHANGE/PLAN CHANGE TRANSACTIONS

ITEM	FIELDS	SIZE	POSITION	ENROLLMENT (EMPLOYER & MCO) 60/61	DISENROLLMENT 51	PLAN ELECTION (PBP CHANGE) 71	PLAN CHANGE 72*

NOTE:

*Type 72-Plan Change transactions are prospective, meaning the current month plus three months. Said another way, current month plus payment month plus two months.

NOTES

ITEM	FIELDS	DESCRIPTION
1	HIC#	Claim Account Number (CAN) plus Beneficiary Identification Code (BIC)
2	Surname	No comment.
3	First Name	No comment.
4	M. Initial	No comment.
5	Sex	1 = male, 2 = female, 0 = unknown
6	Birth Date (YYYYMMDD)	YYYYMMDD
7	EGHP Flag	Y if EGHP; otherwise, blank = not EGHP for type 60, 61, and 71 transactions. For type 72 transactions, Y if EGHP, N if not EGHP, and blank indicates no change.
8	PBP #	3-blanks = non-PBP organizations, COST (if non-PBP), PACE, HCPP, and non-MA Demos; 3-character numeric = PBP number, zero-padded, 001-999 valid for MA, MA-PD, and PDP plans.
9	Election Type	A = AEP; E = IEP, I = ICEP; S = SEP; O = OEP; N = OEPNEW; T = OEPI. MA and MA-PDs have I, A, O, S, N, and T. PDPs have E, A, and S.
10	Contract #	Hxxxx = identifies local MAs and MA-PDs. Rxxxx = identifies regional MAs and MA-PDs. Sxxxx = identifies PDPs. Fxxxx = identifies fallback plans.
11	Application Date	YYYYMMDD -- Either the date the plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper).
12	Transaction Code	51 = disenrollment; 60/61 = enrollment; 71 =plan election (PBP change); and 72 = plan change.
13	Disenrollment Reason	Future use.
14	Effective Date (YYYYMMDD)	YYYYMMDD
15	Segment ID	3-blanks = non-segmented organization transaction; for segmented organization transactions, 3-character numeric = segment number, zero padded, 001-999 valid plan Segment ID range. Only local plans (Hxxxx) may have segments.
16	Filler	N/A
17	Prior Commercial Override	Required if beneficiary is ESRD and wants to enroll in a MA, MA-PD, Cost, HCPP plans. Not required if plan is special-needs-plan (SNP). Alpha-numeric, 0-9 and A-F. Zero (0) and blank = no override.
18	Premium Withhold	D = direct self-pay; S = deduct from SSA benefits; R = deduct from RRB benefits; O = deduct from OPM benefits. The option applies to both Part C and D premiums.

NOTES		
ITEM	**FIELDS**	**DESCRIPTION**
	Option/Parts C-D	
19	Part C Premium Amount (XXXXvXX)	6-digits with leading zeroes, or blank if premium does not apply. Decimal point assumed 2-digits from right, XXXXvXX. Any value other than a blank on a type 72 transaction indicates a change-to value. That is, 000000 is an acceptable change-to value meaning $0.00.
20	Part D Premium Amount (XXXXvXX)	6-digits with leading zeroes, or blank if premium does not apply. Decimal point assumed 2-digits from right, XXXXvXX. Any value other than a blank on a type 72 transaction indicates a change-to value. That is, 000000 is an acceptable change-to value meaning $0.00.
21	Creditable Coverage Flag	Y if covered, N if not covered.
22	Number of Uncovered Months	Count of total months without drug coverage.
23	Employer Subsidy Override Flag	If the beneficiary is in a plan receiving an employer subsidy, but still wants to enroll in a Part D plan, submit the enrollment with the override = Y; otherwise blank.
24	Part D Opt-Out Flag	Applies to full benefit dual eligible and facilitated enrolled beneficiaries. Y = opt-out of auto enrollment; N = do not opt-out of auto-enrollment; blank = no change to opt-out status.
25	Filler	N/A
26	Filler	N/A
27	Secondary Drug Insurance Flag	For type 61 and 71 MA-PD and PDP transactions, Y = beneficiary has secondary drug insurance; N = beneficiary does not have secondary drug insurance available; blank = do not know whether beneficiary has secondary drug insurance. For type 72 MA-PD and PDP transactions, Y = secondary drug insurance available; N = no secondary drug insurance available; blank = no change.
28	Secondary Rx ID	Secondary insurance plan's ID number for beneficiary. Alphanumeric, upper case when alpha; left justified. Upper case printable characters and default value of spaces.
29	Secondary Rx Group	Secondary insurance plan's group ID number for beneficiary. Alphanumeric, upper case when alpha; left justified. Upper case printable characters and default value of spaces.
30	Enrollment Source	A = auto-enrolled by CMS; B = beneficiary election; C = facilitated enrollment by CMS

NOTES		
ITEM	**FIELDS**	**DESCRIPTION**
31	SSN	Social Security Number as it will appear on the MSA beneficiary's trustee bank account. Field valid only for MA MSA plans; otherwise, filler.
32	Trustee Routing Number	Automated Clearing House (ACH) Routing Number for the trustee institution where the beneficiary maintains an MSA account. Field valid only for MA plans; otherwise, filler.
33	Bank Account Number	Medical Savings Account (MSA) Number, bank account number where CMS will deposit the annual MSA contribution. Field valid only for MA plans; otherwise, filler.
34	Bank Account Type	Type of bank account where CMS will deposit the annual MSA contribution. C = checking; S = savings. Field valid only for MA plans; otherwise, filler.
35	Filler	N/A

ATTACHMENT B
AUTO AND FACILITATED ENROLLMENT ADDRESS FILE (ONGOING)

#	Field Name	Len	Pos	Description
1	HICN#	12	1-12	Beneficiary's Health Insurance Claim Number
2	First Name	30	13-42	Beneficiary's First Name
3	Last Name	40	43-82	Beneficiary's Last Name
4	Middle Initial	1	83	Beneficiary's Middle Initial
5	Date of Birth	8	84-91	Format: YYYYMMDD
6	Sex	1	92	Sex Code: M = Male, F = Female, U = Unknown
7	Contract #	5	93-97	
8	PBP #	3	98-100	
9	Segment #	3	101-103	
10	Low-Income Co-Pay Category	1	104	Low-Income Co-Pay Category: 0 = none, not low-income 1 = $2/$5, 2 = $1/$3, 3 = $0, 4 = 15%
11	Enrollment Effective Date	8	105 – 112	Format: YYYYMMDD
12	Beneficiary Address Line 1	40	113 – 152	
13	Beneficiary Address Line 2	40	153 - 192	
14	Beneficiary Address Line 3	40	193 - 232	
15	Beneficiary Address City	40	233 - 272	
16	Beneficiary Address State	2	273 - 274	
17	Beneficiary Zip Code	5	275 - 279	Standard Zip Code
18	Beneficiary Zip Code Extension	4	280 - 283	Zip Code Extension

ATTACHMENT C
ONE-TIME PDP AUTO-ASSIGNMENT NOTIFICATION FILE

Field	Size	Position	Description
1. Health Insurance Claim Number	12	1 – 12	Health Insurance Claim Number
2. Surname	12	13 – 24	Beneficiary Surname
3. First Name	7	25 – 31	Beneficiary Given Name
4. Middle Name	1	32	Beneficiary Middle Initial
5. Sex Code	1	33	Beneficiary Sex Identification Code 0 = Unknown 1 = Male 2 = Female
6. Date of Birth	8	34 – 41	YYYYMMDD Format
7. Medicaid Indicator	1	42	1 = Medicaid 0 = No Medicaid
8. Contract Number	5	43 – 47	Plan Contract Number
9. State Code	2	48 – 49	Beneficiary Residence State Code
10. County Code	3	50 – 52	Beneficiary Residence County Code
11. Filler	7	53 - 59	Spaces
12.. Transaction Type Code **(61)**	2	60 – 61	Transaction Type Code
13. Filler	1	62	Space
14. Effective Date **(20060101)**	8	63 – 70	YYYYMMDD Format; Present only when the Transaction Reply Code is one of the following: 11, 12, 16, 17, 21 – 23, 38, 52, 80, 82 – 84, 100, 109 and 112
15. Filler	1	71	Space
16. Plan Benefit Package ID	3	72 – 74	PBP number
17. Filler	49	75 - 123	Spaces
18. Application Date **(20051015)**	8	124 – 131	The date the plan received the beneficiary's completed enrollment (electronic) or the date the beneficiary signed the enrollment application (paper). Format: YYYYMMDD
19. Filler	30	132 – 161	Spaces
20. Election Type **(S)**	1	162 – 162	A = AEP; E = IEP; I = ICEP; S=SEP; O = OEP; N = OEPNEW; T = OEPI MA/MA-PDs have I, A, O, S, N, T PDPs have E, A, and S
21. Enrollment Source **(A)**	1	163 – 163	A = Auto enrolled by CMS B = Beneficiary Election C = Facilitated enrollment by CMS D = CMS Annual Rollover
22. Filler	1	164 – 164	Space

Field	Size	Position	Description
23. Premium Withhold Option/Parts C-D **(D)**	1	165-165	D = Direct self-pay S = Deduct from SSA benefits R = Deduct from RRB benefits O = Deduct from OPM benefits N = No premium applicable Option applies to both Part C and D Premiums
24. Filler	3	166-168	Spaces
25. Creditable Coverage **(N)**	1	169-169	Y = Covered N = Not Covered
26. Filler	73	170 – 242	Spaces
27. Part D Subsidy Level	3	243-245	LIS percentage
28. Co-Pay Category	1	246 – 246	Definitions of the 4 Categories: 1. $2/$5 Other full subsidy eligibles 2. $1/$3 Full duals with income equal to or less than 100% FPL 3. $0 Full duals that are institutionalized 4. 15% Partial subsidy eligibles
29. Co-Pay Effective Date **(20060101)**	8	247 – 254	Date co-pay category become effective. Format: YYYYMMDD
30. Beneficiary Address Line 1	40	255 – 294	Beneficiary residence line 1 address.
31. Beneficiary Address Line 2	40	295 – 334	Beneficiary residence line 2 address.
32. Beneficiary Address Line 3	40	335 – 374	Beneficiary residence line 3 address.
33. Beneficiary Address Line 4	40	375 – 414	Beneficiary residence line 4 address.
34. Beneficiary Address Line 5	40	415 – 454	Beneficiary residence line 5 address.
35. Beneficiary Address Line 6	40	455 – 494	Beneficiary residence line 6 address.
36. Beneficiary Address City	40	495 – 534	Beneficiary city of residence
37. Beneficiary Address State	2	535 – 536	Beneficiary state of residence
38. Beneficiary Zip Code	9	537 – 545	Beneficiary residence zip code
39. Full Surname	40	546 – 585	Expanded Beneficiary Surname
40. Full First Name	30	586 - 615	Expanded Beneficiary Given Name

Attachment D – Plan Payment Report

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|---------1---------2---------3---------4---------5---------6---------7---------8---------9---------0---------1---------2---------3
  CMS PLAN PAYMENT REPORT                                                                                    PAGE 1 OF 2
  PLAN NUMBER: H9999                                                                                 PAYMENT MONTH: MM/YYYY
  PLAN NAME: ABC HEALTH PLANS INC                                                                      RUN DATE: MM/DD/YYYY

  PAYMENT TYPE:                                                    A/B PAYMENT            D PAYMENT           NET PAYMENT


  1. PROSPECTIVE PAYMENT:
     A/B PAYMENT                    MEMBERS: ZZ,ZZZ,ZZ9    $  Z,ZZZ,ZZZ,ZZ9.99
     D PAYMENT                      MEMBERS: ZZ,ZZZ,ZZ9                          $  Z,ZZZ,ZZZ,ZZ9.99

  2. ADJUSTMENTS TO PRIOR MONTHS AFFECTING A/B & D PAYMENTS:
     (01) DEATH OF BENEFICIARY.....COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
     (02) RETROACTIVE ACCRETION....COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
     (03) RETROACTIVE DELETION.....COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
     (04) CORRECTION TO ACCRETION..COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
     (05) CORRECTION TO DELETION...COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
     (06) PART A ENTITLEMENT LOSS..COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
     (12) CORRECTION TO DEATH......COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
     (19) CORRECTION TO PART B ENT.COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
     (22) RETRO DELETE DUE TO ESRD.COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99
     (35) RETRO CHANGE TO REBATE...COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99    $ -Z,ZZZ,ZZZ,ZZ9.99

  3. ADJUSTMENTS TO PRIOR MONTHS AFFECTING A/B PAYMENTS:
     (07) HOSPICE..................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (08) ESRD.....................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (09) INSTITUTIONAL............COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (10) MEDICAID.................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (11) RETRO SCC................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (13) CORRECTION TO BIRTH......COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (14) CORRECTION TO SEX........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (18) A/B RATE.................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (20) WORKING AGED.............COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (21) NHC......................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (23) DEMO FACTOR ADJUSTMENT...COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (25) RETRO RA RECON ..........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (26) RETRO RA ONGOING.........COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (27) RETRO CHF................COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (29) HOSPICE RATE.............COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99
     (34) PART C BASIC PREMIUM.....COUNT: ZZ,ZZZ,ZZ9    $ -Z,ZZZ,ZZZ,ZZ9.99

  4. ADJUSTMENTS TO PRIOR MONTHS AFFECTING D PAYMENTS:
     (30) PART D PREMIUM...........COUNT: ZZ,ZZZ,ZZ9                          $ -Z,ZZZ,ZZZ,ZZ9.99
     (32) ESTIMATED LICS...........COUNT: ZZ,ZZZ,ZZ9                          $ -Z,ZZZ,ZZZ,ZZ9.99
     (33) ESTIMATED REINSURANCE....COUNT: ZZ,ZZZ,ZZ9                          $ -Z,ZZZ,ZZZ,ZZ9.99
     (36) PART D RATE..............COUNT: ZZ,ZZZ,ZZ9                          $ -Z,ZZZ,ZZZ,ZZ9.99
     (37) PART D RA FACTOR.........COUNT: ZZ,ZZZ,ZZ9                          $ -Z,ZZZ,ZZZ,ZZ9.99

|---------1---------2---------3---------4---------5---------6---------7---------8---------9---------0---------1---------2---------3
NOTE: THE NEGATIVE SIGN SHOULD FLOAT BUT THE DOLLAR SIGN ("$") CAN REMAIN IN A FIXED POSITION.
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CMS PLAN PAYMENT REPORT — PAGE 2 OF 2
PLAN NUMBER: H9999 — PAYMENT MONTH: MM/YYYY
PLAN NAME: ABC HEALTH PLANS INC — RUN DATE: MM/DD/YYYY

PAYMENT TYPE:		A/B PAYMENT	D PAYMENT	NET PAYMENT
5. PLAN LEVEL ADJUSTMENTS:				
A. EDUCATION USER FEE				
1) AMOUNT SUBJECT TO FEE	$ Z,ZZZ,ZZZ,ZZ9.99			
2) X FEE RATE	-0.9999%	$ -Z,ZZZ,ZZZ,ZZ9.99	$ -Z,ZZZ,ZZZ,ZZ9.99	
B. COB USER FEE				
1) PROSP D MEMBERS	ZZ,ZZZ,ZZ9			
2) X FEE RATE	$ -0.99		$ -Z,ZZZ,ZZZ,ZZ9.99	
C. WORKING AGED/DISABLED ADJUSTMENT				
1) ADJUSTED DEMOG PMT	$ Z,ZZZ,ZZZ,ZZ9.99			
2) X PLAN DEMOG RATE	-0.9999%	$ -Z,ZZZ,ZZZ,ZZ9.99		
3) ADJUSTED RA PMT	$ Z,ZZZ,ZZZ,ZZ9.99			
4) X PLAN RA RATE	-0.9999%	$ -Z,ZZZ,ZZZ,ZZ9.99		
D. BIPA 606 PAYMENT REDUCTION				
1) ADJUSTMENTS PRIOR TO 2006		$ -Z,ZZZ,ZZZ,ZZ9.99		
E. BBRA BONUS PAYMENTS				
1) ADJUSTMENTS PRIOR TO 2004		$ -Z,ZZZ,ZZZ,ZZ9.99		
6. CMS ADJUSTMENTS:				
<== DESCRIPTION TEXT FOR MANUAL ADJUSTMENTS ======>		$ -Z,ZZZ,ZZZ,ZZ9.99	$ -Z,ZZZ,ZZZ,ZZ9.99	
<== DESCRIPTION TEXT (OPTIONAL LINES) ============>		$ -Z,ZZZ,ZZZ,ZZ9.99	$ -Z,ZZZ,ZZZ,ZZ9.99	
7. SUBTOTALS BEFORE PREMIUM SETTLEMENT:		$ -Z,ZZZ,ZZZ,ZZ9.99	$ -Z,ZZZ,ZZZ,ZZ9.99	$ -Z,ZZZ,ZZZ,ZZ9.99
8. PREMIUM SETTLEMENT:				
A. PREMIUM WITHHOLDING				
1) PART C PREMIUMS				$ -Z,ZZZ,ZZZ,ZZ9.99
2) PART D PREMIUMS				$ -Z,ZZZ,ZZZ,ZZ9.99
B. LOW INCOME SUBSIDY				
1) PROSPECTIVE LIS				$ Z,ZZZ,ZZZ,ZZ9.99
2) ADJUSTMENTS TO LIS				$ -Z,ZZZ,ZZZ,ZZ9.99
C. LATE ENROLLMENT PENALTY (DIRECT BILL ONLY)				$ -Z,ZZZ,ZZZ,ZZ9.99
9. NET PAYMENT:				$ Z,ZZZ,ZZZ,ZZ9.99

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|---------1---------2---------3---------4---------5---------6---------7---------8---------9---------0---------1---------2---------3
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NOTE: THE NEGATIVE SIGN SHOULD FLOAT BUT THE DOLLAR SIGN ("$") CAN REMAIN IN A FIXED POSITION.

ATTACHMENT E
RXID/RXGROUP/RXBIN/RXPCN DATA FORMAT/INSTRUCTIONS

Contents

1. Introduction

The 4Rx Notification is a data exchange between the Plans and CMS in which the Plans provide CMS with additional information on Plan enrollments to support point of sale and other pharmacy related information needs. A total of eleven (11) data elements are provided of which 4 are Rx related numbers.

The objective is to make available 4Rx data to the TrOOP Facilitator and Coordination of Benefits (COB) contractor beginning 11/15/2005.

2. Plan to CMS / 4Rx Notification

2a. 4Rx Notification File / Record Formats: Once Plans have successfully enrolled individuals in prescription drug plans, they will submit 4Rx notifications for their beneficiaries to CMS in the following format:

Record: 4Rx Notification Header Record

From: Plan ***To: CMS***

Data Field	Length	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	"MMA4RXNH"	This field should always be set to the value "MMA4RXNH". This code allows recognition of the file as a 4Rx Notification file.
Sending Entity	8	9 … 16	X(8)	Sending PDP(8) or HL(5)+3 Spaces	This field provides CMS with the identification of the entity sending the 4Rx Notification File. The value for this field will be supplied by CMS and used in connection with CMS electronic routing and mailbox functions.
File Creation Date	8	17 … 24	X(8)	YYYYMMDD	The date on which the 4Rx Notification file was created by the Plan. This value should be formulated as YYYYMMDD. For example, January 3 2010 would be the value 20100103. This value should agree with the value in the Trailer record.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity	The specific control number generated by the Plan for the 4Rx Notification File. CMS will pass this information back to the plan on the return detail records. (As info, MBD will be assigning its own FCN for tracking through the process.)
Filler	717	34 … 750	X(717)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise
Total Length = 750					

Record: 4Rx Notification Trailer Record

From: Plan ***To: CMS***

Data Field	Length	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	"MMA4RXNT"	This field should always be set to the value "MMA4RXNT". This code allows recognition of the file as a 4Rx Notification file.
Sending Entity	8	9 … 16	X(8)	This value should agree with the Sending Entity in the Header record.	This field provides CMS with the identification of the entity sending the 4Rx Notification File. The value for this field will be supplied by CMS and used in connection with the DCN and connect.direct mailbox functions
File Creation Date	8	17 … 24	X(8)	YYYYMMDD	The date on which the 4Rx Notification file was created by the Plan. This value should be formulated as YYYYMMDD. For example, January 3 2010 would be the value 20100103.
File Control Number	9	25 … 33	X(9)	This value should agree with the File Control Number in the Header record	The specific control number assigned by the Plan for the 4Rx Notification File. CMS will pass this information back to the plan on the return detail records. (As info, MBD will be assigning its own FCN for tracking through the process.)
Record Count	7	34 … 40	9(7)	This value should not include non-numeric characters, such as commas, spaces, dashes, decimals	The total number of Detail records supplied on the 4Rx Notification file. This value should be right-justified in the field, with leading zeros. This value should not include non-numeric characters, such as commas, spaces, dashes, decimals.
Filler	710	41 … 750	X(710)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

Record: 4 Rx Notification Detail (transaction) Record

From: Plan To: CMS

Data Field	Length	Position	Format	Valid Values	Field Definition
Record Type	2	1 … 2	X(2)	"02" = 4Rx Plan Transaction	This field should be set to the value "02," which indicates that this detail record is a 4Rx Plan Transaction. This code allows recognition of the detail record to be processed specifically for 4Rx notification and update.
HICN/RRB Number	12	3 … 14	X(12)	Health Insurance Claim Number or Railroad Retirement Board Number; the Plan will provide whichever type of identification they have available for the beneficiary. The value will be left-justified in the field, and will not contain dashes or spaces.	This field provides either the Social Security Health Insurance Claim Number or the Railroad Retirement Board Number for identification of the individual. The Plan should provide either the HICN or the RRB Number, whichever the Plan has available and active for the individual. The value should be left-justified in the field. The value should not include dashes, decimals, or commas. This is a required field, if the SSN is not provided.
SSN	9	15 … 23	X(9)	Social Security Number. Nine-Byte Numeric.	The Social Security number for the individual. The value should include only numbers. The value should not include dashes, decimals, or commas. This is a required field, if the HICN/RRB is not provided.
Date of Birth (DOB)	8	24 … 31	X(8)	YYYYMMDD	The date of birth of the individual. The value should be formatted as YYYYMMDD. The value should not include dashes, decimals, or commas. The value should include only numbers. This is a required field.
Gender Code	1	32 … 32	X(1)	0 (Zero) = Unknown; 1 = Male; 2 = Female	The gender of the individual. The acceptable values include 0 (Zero) = Unknown, 1 = Male, 2 = Female. This is a required field.
Rx Bin	6	33 … 38	X(6)		The card issuer identifier or a bank identifying number used for network routing. This is a required field.
Rx PCN	10	39 … 48	X(10)		The number assigned by the processor. This is a required field.
Rx ID	20	49 … 68	X(20)		The member ID assigned to the beneficiary. This is a required field.
Rx Group	15	69 … 83	X(15)		The identifying number assigned to the cardholder group or employer group. This is a required field.
Contract Number	5	84 … 88	X(5)		The Contract Number of the Part D enrollment. This is a required field.
PBP Number	3	89 … 91	X(3)		The Plan Benefit Package number for the Part D enrollment. This is a required field.
PBP Enrollment Effective Date	8	92 … 99	X(8)	Beginning of the beneficiary's coverage within the given PBP. YYYYMMDD	The beginning date of the individual's coverage within the specified Plan Benefit Package (PBP). This is a required field.
Detail Record Sequence Number	7	100..106	9(7)		Unique number (1…….n) assigned by Plan.
Filler	644	107..750	X(644)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

2b. 4Rx Notification Instructions:

The Plans may submit one or more 4Rx Notification files to CMS during any CMS business day via Connect:Direct (NDM) or the Sterling Electronic Mailbox (Secure FTP). There is not a minimum or maximum limit with respect to 4Rx Notification files or transactions.

4Rx Notification files should be formulated to the record formats and field definitions described Section 2a above. The 4Rx Notification files should be in flat file structure and conform to CMS naming conventions.

The MBD will recognize 4Rx Notification Files by the information supplied in the Header and Trailer records. Header information is considered critical as it will be used by CMS to track, control, formulate and route files and transactions through the MBD process and communicate responses back to the Plans.

The Detail records on the 4Rx Notification file should be formulated to identify a Plan enrollee, identify the current Contract and Plan of the enrollee, and to provide the four prescription drug coverage fields for the enrollee's coverage. Each Detail record of a 4Rx Notification file will be considered a 4Rx "transaction."

The Plans should not submit prospective enrollment information in the 4Rx Notification files. The 4Rx Notification files should contain only detail records for current Plan enrollments.

The Plans should utilize the following naming standard for the 4Rx Notification file:

*P#*MBD.#RXN4.xxxxxxxx.IN.QUERY.NDM

The Placeholder "xxxxxxxx" would be the Sending Entity Name. For definition of Sending Entity Name, please see Section 2a. 4Rx Notification File / Record Formats.

It should be noted that if a Plan submits more than one 4Rx Notification File during a given business day, only one 4Rx Response File will be generated by the MBD for transmission back to the Plan. It is possible that all 4Rx Notification Files submitted to CMS during a given day may not be fully processed by CMS. For example, if a Plan submits three 4Rx Notification Files, it is possible that detail records will be returned in the 4Rx Response File will be for only a portion of one of the three 4Rx Notification Files submitted. In addition, the details records absent from the 4Rx Response File may be related to any of the three 4Rx Notification Files submitted by the Plan as the MBD may not process them in the order they are received. The "Detail Record Sequence Number" located in each detail record/transaction can be used by the Plan to track transactions sent to and received from CMS. (See the next section of these instructions for more information on response transactions).

3. CMS to Plans / 4Rx Response

3a. 4Rx Response File / Record Formats: CMS will send 4Rx Response Files to Plans in the following format.

Record: 4Rx Response File Header Record

From: CMS ***To: Plans***

Data Field	Length	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	"CMS4RXNH"	This field will always be set to the value "CMS4RXNH". This code allows recognition of the file as a 4Rx Response file.
Sending Entity (CMS)	8	9 … 16	X(8)	"MBD " (MBD + 5 Spaces)	This field will always be set to the value "MBD ". The value specifically is MBD + 5 following Spaces.
File Creation Date	8	17 … 24	X(8)	YYYYMMDD	The date on which the 4Rx Response file was created by CMS. This value will be formulated as YYYYMMDD. For example, January 3 2010 would be the value 20100103.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity (CMS)	The specific control number generated by the MBD for the 4Rx Response File. CMS will utilize this value to track the 4Rx Response file through CMS processing and archive.
Filler	717	34 … 750	X(717)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

Record: 4Rx Response File Trailer Record

From: CMS ***To: Plans***

Data Field	Length	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	"CMS4RXNT"	This field will always be set to the value "CMS4RXNT". This code allows recognition of the file as a 4Rx Response file.
Sending Entity (CMS)	8	9 … 16	X(8)	"MBD " (MBD + 5 Spaces)	This field will always be set to the value "MBD ". The value specifically is MBD + 5 following Spaces.
File Creation Date	8	17 … 24	X(8)	YYYYMMDD	The date on which the 4Rx Response file was created by CMS. This value will be formulated as YYYYMMDD. For example, January 3 2010 would be the value 20100103. This should agree with the values in the Header record.
File Control Number	9	25 … 33	X(9)	This value will agree with the File Control Number in the 4Rx Response Header record.	The specific control number assigned by CMS for the 4Rx Response File. CMS will utilize this value to track the 4Rx Response file through CMS processing and archive.
Record Count	7	34 … 40	9(7)	Total number of Detail records on the 4Rx Response File.	The total number of detail records on the 4Rx Response File.
Filler	710	41 … 500	X(710)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be references for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

Record: 4Rx Response File Detail (transaction) Record

(This record is produced for all 4Rx transactions)

From: CMS ***To: Plans***

Data Field	Length	Position	Format	Valid Values	Field Definition
Original Detail Record	106	1 …106	X(106)	The first 106 positions of the original Detail Record (transaction) supplied by the Plan.	This field provides the full original Detail record provided by the Plan on the 4Rx Notification File.
Transaction Error Code	6	107…112	X(6)	See Section **4.** 4Rx Notification Error Condition Table below for acceptable values.	See Section **4.** 4Rx Notification Error Condition Table.
Sending Entity	8	113…120	X(8)	Value of Sending Entity provided by the Plan on the 4Rx Notification Header Record.	Sending Entity within Header Record on related 4Rx Notification File
File Control Number	9	121...129	X(9)	Value of File Control Number provided by Plan on the 4Rx Notification Header Record.	File Control Number from Header Record on related 4Rx Notification File
File Creation Date	8	130..137	X(8)	Value of File Creation Date provided on the 4Rx Notification Header Record.	File Creation Date from Header Record on related 4Rx Notification File
Filler	612	138…750	X(612)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

3b. 4Rx Response Process:

If the MBD ***successfully locates*** the beneficiary on the database tables, then the MBD will confirm the beneficiary's Plan Benefit Package elections through the PBP Number, Contract Number, and PBP Enrollment Effective Date supplied on the 4Rx Notification file Detail record. The MBD will ensure that the information in the Detail Record is existing enrollment data. The MBD will then:

- Update (replace) the beneficiary's prescription drug coverage fields with the four Rx fields supplied on the Detail record; and
- Create a Detail Record to be returned to the Plan in a 4Rx Response File containing the Original Detail Record, a Transaction Error Code indicating the 4Rx Notification Detail (transaction) Record was successfully processed by the MBD, and key identifying information from the Header record of the associated 4Rx Notification File.

If the MBD is ***unsuccessful in locating*** the beneficiary on the database tables or 4Rx Notification Detail (transaction) Record contains an error, the MBD will then:

- Create a Detail Record to be returned to the Plan in a 4Rx Response File containing the Original Detail Record, a Transaction Error Code indicating the error condition that prevented the 4Rx transaction from being processed, and key identifying information from the Header Record of the associated 4Rx Notification File.

The error conditions that could prevent a 4Rx transaction from being processed by the MBD are described in Section 4 below.

The MBD will formulate the 4Rx Response File as a flat file in the format and validation specification as detailed further in this document.

The MBD will utilize the following naming standard for the 4Rx Response File:
*P#*MBD.#RXN4.xxxxxxxx.OUT.RSLTS

(The Placeholder "xxxxxxxx" will be set to the same value as the Sending Entity Name of the incoming 4Rx Notification File.)

4. 4Rx Notification Error Messages

4a. File Level Errors

Table under construction

ATTACHMENT F
COB DATA FORMAT AND INSTRUCTIONS

COB File Data Element Definitions and Instructions for Part D Plans

This document defines and provides instructions on the use of data elements found in the COB File Formats. The COB File contains the Other Health Insurance (OHI) information of enrollees in that Part D Plan. The OHI information contained in the COB File has been collected by the COB Contractor through its VDSAs, COBAs, and other data exchanges with non-Part D payers (PBMs, insurers, Employer GHP sponsors, State programs); questionnaires filled out by beneficiaries, employers, and providers; and from leads submitted from Part D Plans and other Medicare contractors. The information collected by the COB Contractor and provided to the Part D Plan is meant to assist the Part D Plan in fulfilling its requirement to coordinate with OHI.

The COB File consists of a Detail (DTL) record identifying the Part D Plan's Contract Number, the Plan Benefit Package number, and identifying information for the enrollee whose OHI is contained in the records attached to the DTL record. Two types of records may be subordinate (attached) to the DTL record: up to twenty (20) Primary (PRM) records and up to twenty (20) Supplemental (SUP) records. PRM records contain OHI that is primary to Part D. "Primary" does not necessarily refer to a single primary insurance, but to all occurrences of insurance that are statutorily required to pay prior to (primary to) Part D. There may be multiple occurrences of primary insurance. Each occurrence of primary insurance will be contained in PRM records subordinate to the DTL record. SUP records contain all supplemental insurance that pays after (supplemental to) Part D. Each occurrence of supplemental insurance will be contained in SUP records subordinate to the DTL record.

The COB File will contain full-record replacements for enrollees with newly discovered or changed OHI. If an enrollee's OHI record has been added, changed, or deleted, this will trigger a full replacement of that enrollee's DTL and subordinate PRM and SUP records. The Part D Plan will replace its entire existing OHI profile for an enrollee with the most recent DTL and subordinate PRM and SUP records for that enrollee.

The Medicare Beneficiary Database (MBD) sends the COB File to Partd Plans via the MARx system. The COB File is automatically sent to Part D Plans when, at enrollment, the MBD already contains OHI information on that enrollee. For instance, if an individual has OHI, dis-enrolls from Part D Plan A, and then enrolls in Part D Plan B, all of the OHI that the MBD held and had previously sent to Plan A will be automatically sent to Plan B in the COB File.

The COB File will be sent out to Part D Plans as the COB Contractor collects OHI and applies records to the MBD. This can occur as often as daily. The Part D Plan may or may not receive the COB File daily, and if it does it will only receive records for enrollees with changed or newly discovered OHI. Most of the data exchanges that the COB Contractor administers for CMS are on a monthly frequency. Each data exchange partner has its own submission schedule, however. The COB Contractor can receive file submissions from data exchange partners on any given day. The COB Contractor conducts development (phone calls, mailed

questionnaires) on a continual basis. The COB Contractor may apply records originating from development or data exchanges to the MBD any day. As soon as the records are applied to the MBD, the COB File will be sent to the Part D Plan of the enrollee with OHI.

The Part D Plan will use the elements contained in the PRM and SUP records to make payment determinations, recover mistaken payments, identify whether or not payments made by OHI count towards TrOOP, and to populate the reply to the pharmacy.

The CMS is currently drafting specific guidelines for secondary payments by Part D Plans and recovery of mistaken payments made by the Part D Plan when another insurance was statutorily required to make primary payment. The Medicare Secondary Payer (MSP) rules can be found at 42 U.S.C. § 1395y(b). Under provisions found in § 1860D-2(a) (4) of the MMA, the MSP rules have been incorporated in the MMA and are applicable to Part D Plans as payers of Medicare benefits and to non-Part D GHP and non-GHP prescription drug payers that meet the MSP rules.

In some cases, the Part D plan will make mistaken primary payments (if the COB Contractor, CMS, and the Part D plan are all unaware of any primary coverage). Under other circumstances, the Part D plan will make conditional payments. These circumstances include:

- When the Part D plan is aware that the enrollee has WC/no-fault/liability coverage but does not know whether the drugs for which a bill is sent are related to the WC/no-fault/liability incident;
- When the Part D plan has learned of potential primary coverage and has sent information to the COBC for development and *it chooses to wait for validation* before considering itself a secondary payer. Note that this option is entirely up to the plan; it may act as a secondary payer immediately or wait for validation, depending upon how confident it is that the information it received is valid;
- When the Part D plan is aware that the primary WC/no-fault/liability coverage applies but the primary payer will not make prompt payment.

When these mistaken or conditional primary payments are made, the Part D plan *is required to* recover the primary payment from the relevant employer, insurer, WC/no-fault/liability carrier or insurer, or enrollee. The Part D plan will also be subject to audit or reporting requirements. The CMS is currently writing and will shortly publish further guidance on these and other Medicare Secondary Payer procedures.

PRM Record Layout Elements:

OHI contained in the PRM record is primary to (pays before) Part D. The following are definitions and instructions on the use of elements contained in the PRM record layout. Some of the PRM record layout elements are the same as elements contained in the PRM record layout (* indicates that the element is found in both), but may have slightly different definitions and instructions. Not all element fields will be populated, depending on the information that the COB Contractor possesses when it applied the record to the MBD.

RxID Number*

The NCPDP standard Rx Identification Number used for network drug benefit of the primary insurance. The Part D Plan displays this in the reply to the pharmacy. It may be used to identify and individual in the recovery of mistaken payments. CMS will provide guidance for recoveries to Part D Plans.

RxGroup Number*

The NCPDP standard Rx Group Number used for network drug benefit of the primary insurance. The Part D Plan displays this in the reply to the pharmacy. It may be used to identify and individual in the recovery of mistaken payments, as well.

RxBIN Number*

The NCPDP standard International Benefit Identification Number used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy. It may be used to identify and individual in the recovery of mistaken payments, as well.

RxPCN Number*

The NCPDP standard Processor Control Number used for network drug benefit routing of the primary insurance. The Part D Plan displays this in the reply to the pharmacy. It may be used to identify and individual in the recovery of mistaken payments, as well.

RX Plan Toll Free Number*

The help desk number of the pharmacy benefit of the primary insurance. The Part D Plan displays this in the reply to the pharmacy.

Sequence Number*

The unique identifier for the primary PRM occurrence. This may be used to identify the PRM occurrence when inquiring about a record to the COB Contractor.

COB Source Code*

The code the COB Contractor, Common Working File, and MBD use to identify which process the COB Contractor received primary insurance information from. This may be used for customer service and when inquiring about a record to the COB Contractor.

MSP Type

The reason for Medicare Secondary Payer, i.e. why the insurance is primary to Medicare. For GHP MSP Reason codes (A, B, G), the Part D Plan rejects primary payment. The GHP is statutorily required to make primary payment. The Part D Plan makes secondary payment. For non-GHP MSP Reason codes (C, D, E, F, H, I, L), the

Part D Plan makes conditional primary payment, as these MSP types may be incident related, so without a diagnosis code the Part D Plan can not determine whether or not the non-GHP insurance is primary for that particular claim, unless the Part D Plan is certain that the claim is related to the incident. If the Part D Plan is certain that the claim is incident related, and that primary insurance for this incident exists, it should reject primary payment in the same way it rejects GHP MSP primary insurance. If the Part D Plan makes a conditional primary payment, it must reconcile with the non-GHP insurance post point of sale.

Coverage Code*

Identifies whether the coverage offered by the primary insurance is a network drug or non-network drug benefit. When the primary insurance is a network drug benefit coverage type (U), the record will include routing information (BIN and possibly PCN). When the primary insurance is a non-network drug benefit coverage type (V & Z) the Group and Individual Policy Number Fields may be populated.

Insurer's Name*

The name of the primary insurance carrier. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Insurer's Address-1*
Insurer's Address-2*
Insurer's City*
Insurer's State*
Insurer's Zip Code*

The Address, city, state, and zip code of the primary insurance carrier. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Insurer TIN

The Tax Identification Number (TIN) of primary insurance carrier. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Individual Policy Number*

The Individual Policy Number used for non-network drug benefit primary insurance. The Part D Plan uses this to identify non-network drug benefit primary insurance. It may be used to identify and individual in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Group Policy Number*

The Group Policy Number used for non-network drug benefit primary insurance. The Part D Plan uses this to identify non-network drug benefit primary insurance. It may be used to identify and individual in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Effective Date*

The Medicare Secondary Payer start date. For MSP types D, E, L it identifies the date of the accident, illness, or injury.

Termination Date*

Medicare Secondary Payer end date. Identifies whether or not the primary insurance has terminated. If the insurance is open, the field will be populated with all zeros.

Relationship Code*

Relationship to primary insurance policyholder used for MSP determinations.
01=Self
02=Spouse
03=Child
04=Other

Payor ID*

Future

Person Code*

The NCPDP standard Person code the plan uses to identify specific individuals on the primary insurance policy. Used for routing of network drug benefit. The Part D Plan displays this in the reply to the pharmacy. It may be used in the recovery of mistaken payments, as well.

Payer Order*

The order of payment for primary insurance. The Part D Plan displays in the reply to the pharmacy in order according to Payment Order Indicator. The lowest number in ascending order (001 to 400) is the first primary insurance to be displayed in the reply to the pharmacy. OHI with a payment order less than 401 will be displayed prior (primary to) to the Part D Plan. The rules that the COB Contractor will use to assign the Payer Order are attached for reference.

Policy Holder's First Name

The first name of the primary GHP (MSP Types: A, B, G) insurance policy holder. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Policy Holder's Last Name

The Last name of the primary GHP (MSP Types: A, B, G) insurance policy holder. It may be used to identify and individual in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Policy Holder's SSN

The Social Security Number of the primary GHP (MSP Types: A, B, G) insurance policy holder. It may be used to identify and individual in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Employee Information Code

Not used.

Employer's Name

The name of Employer sponsor of primary GHP (MSP Reason codes: A, B, G) insurance. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Employer's Address 1
Employer's Address 2
Employer's City
Employer's State
Employer's Zip Code

The address, city, state, and zip code of the Employer sponsoring the primary GHP (MSP Reason codes: A, B, G) insurance. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Claim Diagnosis Code 1
Claim Diagnosis Code 2
Claim Diagnosis Code 3
Claim Diagnosis Code 4
Claim Diagnosis Code 5

ICD-9-CM Diagnosis code – International Classification of Diseases, 9th Edition, Clinical Modification. Official system of assigning codes to diagnoses and procedures associated with hospital utilization in the U.S. National Center for Health Statistics and

CMS are the U.S. governmental agencies responsible for overseeing all changes to the ICD-9-CM. No instructions at this time

Attorney's Name

The name of the attorney handling the incident related case (MSP Types D: Automobile Insurance, No Fault, E: Workers' Compensation, L: Liability) for the enrollee. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Attorney's Address 1
Attorney's Address 2
Attorney's City
Attorney's State
Attorney's Zip

The address of the attorney. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Lead Contractor

The assigned lead Medicare claims payment contractor responsible for developing, tracking and recovering Medicare payments made where the enrollee received payments from a liability insurer. It may be used in the recovery of mistaken payments, as well. CMS will provide guidance for recoveries to Part D Plans.

Class Action Type

Assigned where liability case is a class action lawsuit involving more than one Medicare beneficiary.

Administrator Name

The administrator of Workers' Compensation (WC) Set Aside Settlement that CMS will bill for payment of future claims related to the incident that allowed the enrollee to receive WC benefits. CMS is developing payment and recovery rules for Worker's Compensation Set-Asides.

Administrator Address 1
Administrator Address 2
Administrator City
Administrator State
Administrator Zip

The address, city, state, and zip code of the WC Set-Aside Settlement. CMS is developing payment and recovery rules for Worker's Compensation Set-Asides.

WCSA Amount

Worker's Compensation Set-Aside Amount. CMS is developing payment and recovery rules for Worker's Compensation Set-Asides.

WCSA Indicator

Worker's Compensation Set-Aside Indicator. CMS is developing payment and recovery rules for Worker's Compensation Set-Asides.

SUP Record Layout Elements:

OHI contained in the SUP record is supplemental to (pays after) Part D. The following are definitions and instructions on the use of elements contained in the SUP record layout. Some of the SUP record layout elements are the same as elements contained in the PRM record layout, but may have slightly different definitions and instructions. Not all element fields will be populated, depending on the information that the COB Contractor possesses when it applied the record to the MBD.

RxID Number*

The NCPDP standard Rx Identification Number used for network drug benefit of the supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.

RxGroup Number*

The NCPDP standard Rx Group Number used for network drug benefit of the supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.

RxBIN Number*

The NCPDP standard International Benefit Identification Number used for the network drug benefit routing of supplemental insurance. The Part D Plan displays this in the reply to the pharmacy.

RX Plan Toll Free Number*

The help desk number of the pharmacy benefit. The Part D Plan displays this in the reply to the pharmacy.

Sequence Number*

The unique identifier for the supplemental SUP occurrence. This may be used to identify the SUP occurrence when inquiring about a record to the COB Contractor.

COB Source Code*

The code the COB Contractor, Common Working File, and MBD use to identify which process the COB Contractor received supplemental insurance information from. This may be used for customer service and when inquiring about a record to the COB Contractor.

Supplemental Type Code

The type of supplemental insurance contained in the record. The Part D Plan will use this to determine if the payments made by this supplemental insurance counts towards TrOOP or not. Supplemental Insurance Type Codes P (PAP), Q (SPAP), R (Charity) count towards TrOOP. All other codes do not count towards TrOOP.

Coverage Code*

Identifies whether the drug benefit offered by supplemental insurance is a network drug or non-network drug benefit. When the supplemental insurance is a network drug benefit coverage type (U), the record will include routing information (BIN and possibly PCN). When the supplemental insurance is a non-network drug benefit coverage type (V & Z) the Group and Individual Policy Number Fields will be populated

Insurer's Name*

The name of the supplemental insurance carrier. The Part D Plan uses this to identify supplemental insurance carrier.

Insurer's Address-1*
Insurer's Address-2*
Insurer's City*
Insurer's State*
Insurer's Zip Code*

The address, city, state, and zip code of the supplemental insurance carrier. This may be used for customer service.

Individual Policy Number*

The Individual Policy Number used for non-network drug benefit supplemental insurance. The Part D Plan uses to identify non-network drug benefit supplemental insurance.

Group Policy Number*

The Group Policy Number used for non-network drug benefit supplemental insurance. The Part D Plan uses to identify non-network drug benefit supplemental insurance.

Effective Date*

The supplemental insurance start date.

Termination Date*

The supplemental insurance end date. Identifies whether or not the supplemental insurance has terminated. If the insurance is open, the field will be populated with all zeros.

Relationship Code*

Relationship to supplemental insurance policyholder. No instructions at this time.

Payor ID*

Future

Person Code*

The NCPDP standard Person code the supplemental insurance uses to identify specific individuals on the supplemental insurance policy. Used for routing of network drug benefit. The Part D Plan displays this in the reply to the pharmacy.

Payer Order*

The order of payment for supplemental insurance. The Part D Plan displays in the reply to the pharmacy in order according to the Payment Order Indicator. The lowest number in ascending order (401 to 999) is the first supplemental insurance to be displayed in the reply to the pharmacy. OHI with a payment order greater than or equal to 401 will be displayed after (secondary/supplemental to) the Part D Plan. The rules that the COB Contractor will use to assign the Payer Order are attached for reference.

Payment Order Rules

Payment Order Range	Payment Type	MSP Reason	Supplemental Insurance Type	Coverage (to Medicare)
001 – 100	GHP w/ Patient Relationship= 1	A, B, G		Primary
101 – 200	GHP w/ Patient Relationship>= 2	A, B, G		Primary
201 – 300	Non-GHP	C, D, E, F, H		Primary
301 – 400	For Future Use			N/A
401 – 500	Secondary Insurer w/ Person Code = 1		L, M, O,	Secondary

Payment Order Range	Payment Type	MSP Reason	Supplemental Insurance Type	Coverage (to Medicare)
501 – 600	Secondary Insurer w/ Person Code>= 2		L, M, O	Secondary
601 – 700	Federal Government Programs		T, 2	Secondary
701 – 800	ADAPs, PAPs, Charities		N, P, R, S	Secondary
801 – 900	SPAPs		Q	Secondary
901 – 999	Medicaid		1	Secondary

1. The 'Payment Order Indicator' will indicate payment ordering; the lowest number in ascending order (001 to 999) is the first coverage to be billed at the pharmacy.

2. All drug coverages with a payment order less than 401 will be billed (using the COB to MBD – Other Insurance PRM format) prior (primary to) to the Part D Plan; all drug coverages with a payment order greater than or equal to 401 will be billed (using the COB to MBD – Other Insurance SUP format) after (secondary to) the Part D Plan.

3. Employer Group Health Plans (EGHP) will include MSP Types A (Working Aged), B (ESRD) and G (Disabled). These will be applied payment orders in the 001 to 200 range.

4. Non-EGHP will include MSP Types D (Automobile Insurance, No Fault), E (Workers' Compensation), L (Liability) and H (Black Lung). These will have applied payment orders in the 201 to 300 range.

5. If there are two GHPs with a Patient Relationship Code of '1', the GHP with the earlier effective date shall go before the GHP with the later effective date.

6. If there are two GHPs with Patient Relationship Code of '1', and with the same effective date, the GHP with the first accretion date (validated against the date timestamp or DCN) shall go before the later accretion date.

7. If there are two GHPs with Patient Relationship Code of '2' or more, the GHP with the earlier effective date shall go before the GHP with the later effective date.

8. If there are two GHPs with Patient Relationship Code of '2' or more, and with the same effective date, the GHP with the first accretion date (validated against the date timestamp or DCN) shall go before the later accretion date.

9. If there are two insurers with Person Code of '1', the insurer with the first accretion date (validated against the date timestamp or DCN) shall go before the later accretion date.

10. If there are two insurers with Person Code of '2' or more, the insurer with the first accretion date shall go before the later accretion date.

11. If the record represents a supplemental insurer, the Insurance Type code shall determine the order. Within the list of Supplemental Types, those for Federal Government Programs shall take precedence over those for ADAPs, PAPs and Charities, which shall take precedence over those for SPAPs, which shall take precedence over Medicaid.

Detail Records: Indicates the beginning of a series of beneficiary subordinate detail records

Data Field	Length	Position	Format	Valid Values
Record Type	3	1 … 3	CHAR	"DTL"
HICN/RRB Number	12	4 … 15	CHAR	Spaces if unknown
SSN	9	16 … 24	ZD	000000000 if unknown
Date of Birth (DOB)	8	25 … 32	CHAR	YYYYMMDD
Gender Code	1	33 … 33	CHAR	0=unknown, 1 = male, 2 = female
Contract Number	5	34 … 38	CHAR	
Plan Benefit Package	3	39 … 41	CHAR	
Action Type	1	42 … 42	CHAR	2 = Full replacement
Filler	958	43 … 1000	CHAR	Spaces

Record Length = 1000

Primary Record: Subordinate to Detail Record (unlimited occurrences)

Data Field	Length	Position	Format	Valid Values
Record Type	3	1 … 3	CHAR	"PRM"
HICN/RRB Number	12	4 … 15	CHAR	Spaces if unknown
SSN	9	16 … 24	ZD	000000000 if unknown
Date of Birth (DOB)	8	25 … 32	CHAR	YYYYMMDD
Gender Code	1	33 … 33	CHAR	0=unknown, 1 = male, 2 = female
RxID Number*	20	34 … 53	CHAR	
RxGroup Number*	15	54 … 68	CHAR	
RxBIN Number*	6	69 … 74	CHAR	
RxPCN Number*	10	75 … 84	CHAR	
RX Plan Toll Free Number*	18	85 … 102	CHAR	
Sequence Number*	3	103 … 105	CHAR	

Data Field	Length	Position	Format	Valid Values
COB Source Code*	5	106 … 110	CHAR	11100 Non Payment/Payment Denial 11101 IEQ 11102 Data Match 11103 HMO 11104 Litigation Settlement BCBS 11105 Employer Voluntary Reporting 11106 Insurer Voluntary Reporting 11107 First Claim Development 11108 Trauma Code Development 11109 Secondary Claims Investigation 11110 Self Report 11111 411.25 11112 BCBS Voluntary Agreements 11113 Office of Personnel Management (OPM) Data Match 11114 Workers' Compensation Data Match 11118 Pharmacy Benefit Manager (PBM) 11120 COBA 11125 Recovery Audit Contractor (RAC) 1 (April Release) 11126 RAC 2 (April Release) 11127 RAC 3 (April Release) P0000 PBM S0000 Assistance Program Note: Contractor numbers 11100 - 11199 are reserved for COB
MSP Reason (Entitlement Reason from COB)	1	111 … 111	CHAR	A Working Aged B ESRD C Conditional Payment D Automobile Insurance, No fault E Workers Compensation F Federal (public) G Disabled H Black Lung I Veterans L Liability
Coverage Code*	1	112 … 112	CHAR	A=Hospital and Medical U=Drug (network benefit) V=Drug with Major Medical (non-network benefit) W=Comprehensive, Hospital, Medical, Drug (network) X=Hospital and Drug (network) Y=Medical and Drug (network) Z=Health Reimbursement Account (hospital, medical, and drug)
Insurer's Name*	32	113 … 144	CHAR	
Insurer's Address-1*	32	145 … 176	CHAR	
Insurer's Address-2*	32	177 … 208	CHAR	
Insurer's City*	15	209 … 223	CHAR	
Insurer's State*	2	224 … 225	CHAR	
Insurer's Zip Code*	9	226 … 234	CHAR	
Insurer TIN	10	235 … 244	CHAR	
Individual Policy Number*	17	245 … 261	CHAR	
Group Policy Number*	20	262 281	CHAR	
Effective Date*	8	282 … 289	ZD	CCYYMMDD

Data Field	Length	Position	Format	Valid Values
Termination Date*	8	290 … 297	ZD	CCYYMMDD
Relationship Code*	2	298 … 299	CHAR	01=Bene is Policy Holder 02=Spouse 03=Child 04=Other
Payor ID*	10	300 … 309	CHAR	*This is a future element*
Person Code*	3	310 … 312	CHAR	
Payer Order*	3	313 … 315	ZD	
Policy Holder's First Name	9	316 … 324	CHAR	
Policy Holder's Last Name	16	325 … 340	CHAR	
Policy Holder's SSN	12	341 … 352	CHAR	
Employee Information Code	1	353 … 353	CHAR	P=Patient S=Spouse M=Mother F=Father
Employer's Name	32	354 … 385	CHAR	
Employer's Address 1	32	386 … 417	CHAR	
Employer's Address 2	32	418 … 449	CHAR	
Employer's City	15	450 … 464	CHAR	
Employer's State	2	465 … 466	CHAR	
Employer's Zip Code	9	467 … 475	CHAR	
Filler	20	476 … 495	CHAR	
Employer TIN	10	496 … 505	CHAR	
Filler	20	506 … 525	CHAR	
Claim Diagnosis Code 1	10	526 … 535	CHAR	
Claim Diagnosis Code 2	10	536 … 545	CHAR	
Claim Diagnosis Code 3	10	546 … 555	CHAR	
Claim Diagnosis Code 4	10	556 … 565	CHAR	
Claim Diagnosis Code 5	10	566 … 575	CHAR	
Attorney's Name	32	576 … 607	CHAR	
Attorney's Address 1	32	608 … 639	CHAR	
Attorney's Address 2	32	640 … 671	CHAR	
Attorney's City	15	672 … 686	CHAR	
Attorney's State	2	687 … 688	CHAR	
Attorney's Zip	9	689 … 697	CHAR	
Lead Contractor	9	698 … 706	CHAR	
Class Action Type	2	707 … 708	CHAR	
Administrator Name	32	709 … 740	CHAR	
Administrator Address 1	32	741 … 772	CHAR	
Administrator Address 2	32	773 … 804	CHAR	
Administrator City	15	805 … 819	CHAR	
Administrator State	2	820 … 821	CHAR	
Administrator Zip	9	822 … 830	CHAR	
WCSA Amount	9	831 … 839	ZD	Integer value
WCSA Indicator	2	840 … 841	CHAR	
Filler	159	842 … 1000	CHAR	

Record Length = 1000

*Indicates that these fields have same position in PRM and SUP record layouts

Supplemental Record: Subordinate to Detail Record (unlimited occurrences)

Data Field	Length	Position	Format	Valid Values
Record Type	3	1 … 3	CHAR	"SUP"
HICN/RRB Number	12	4 … 15	CHAR	Spaces if unknown
SSN	9	16 … 24	ZD	000000000 if unknown
Date of Birth (DOB)	8	25 … 32	CHAR	YYYYMMDD
Gender Code	1	33 … 33	CHAR	0=unkonwn, 1 = male, 2 = female
RxID Number*	20	34 … 53	CHAR	
RxGroup Number*	15	54 … 68	CHAR	
RxBIN Number*	6	69 … 74	CHAR	
RxPCN Number*	10	75 … 84	CHAR	
RX Plan Toll Free Number*	18	85 … 102	CHAR	
Sequence Number*	3	103 … 105	CHAR	
COB Source Code*	5	106 … 110	CHAR	11100 Non Payment/Payment Denial 11101 IEQ 11102 Data Match 11103 HMO 11104 Litigation Settlement BCBS 11105 Employer Voluntary Reporting 11106 Insurer Voluntary Reporting 11107 First Claim Development 11108 Trauma Code Development 11109 Secondary Claims Investigation 11110 Self Report 11111 411.25 11112 BCBS Voluntary Agreements 11113 Office of Personnel Management (OPM) Data Match 11114 Workers' Compensation Data Match 11118 Pharmacy Benefit Manager (PBM) 11120 COBA 11125 Recovery Audit Contractor (RAC) 1 (April Release) 11126 RAC 2 (April Release) 11127 RAC 3 (April Release) P0000 PBM S0000 Assistance Program Note: Contractor numbers 11100 - 11199 are reserved for COB
Supplemental Type Code	1	111 … 111	CHAR	L=Supplemental M=Medigap N=State Program (Non Qualified SPAP) O=Other P=Patient Assistance Program Q=Qualified State Pharmaceutical Assistance Program (SPAP) R=Charity S=AIDS Drug Assistance Program T=Federal Health Program 1=Medicaid 2=Tricare
Coverage Code*	1	112 … 112	CHAR	U=Drug (network benefit) V=Drug with Major Medical (non-network benefit)
Insurer's Name*	32	113 … 144	CHAR	
Insurer's Address-1*	32	145 … 176	CHAR	
Insurer's Address-2*	32	177 … 208	CHAR	
Insurer's City*	15	209 … 223	CHAR	
Insurer's State*	2	224 … 225	CHAR	
Insurer's Zip Code*	9	226 … 234	CHAR	
Filler	10	235 … 244	CHAR	Spaces

Data Field	Length	Position	Format	Valid Values
Individual Policy Number*	17	245 … 261	CHAR	
Group Policy Number*	20	262 … 281	CHAR	
Effective Date*	8	282 … 289	ZD	CCYYMMDD
Termination Date*	8	290 … 297	ZD	CCYYMMDD
Relationship Code*	2	298 … 299	CHAR	01=Bene is Policy Holder 02=Spouse 03=Child 04=Other
Payor ID*	10	300 … 309	CHAR	
Person Code*	3	310 … 312	CHAR	
Payer Order*	3	313 … 315	ZD	
Filler	20	316 … 335	CHAR	
Filler	665	336 … 1000	CHAR	Spaces

Record Length = 1000

*Indicates that these fields have same position in PRM and SUP record layouts

Coordination of Benefits is a contract specific report file that is created daily.

General Organization of Records:

Detail Record (DTL) Record 1
Primary (PRM) records associated with 'DTL' Record 1
Supplemental (SUP) records associated with 'DTL' Record 1
'DTL' Record 2
'PRM' records associated with 'DTL' Record 2
'SUP' records associated with 'DTL' Record 2
'DTL' Record 3
'PRM' records associated with 'DTL' Record 3
'SUP' records associated with 'DTL' Record 3
…
'DTL Record n
'PRM' records associated with 'DTL' Record n
'SUP' records associated with 'DTL' Record n

ATTACHMENT G
CENTRAL OFFICE CONTACT LIST

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ATTACHMENT H
BANKING INFORMATION FORM
PAYMENT INFORMATION FORM

As Government vendors, organizations with Medicare contracts are paid by the Department of Treasury through an Electronic Funds Transfer (EFT) program. Government vendor payments are directly deposited into corporate accounts at financial institutions on the expected payment date. Additionally, CMS must have the EIN/TIN and associated name as registered with the IRS.

Please provide the following information to assist the Centers for Medicare and Medicaid Services in establishing payment arrangements for your organization.

ORGANIZATION INFORMATION

NAME OF ORGANIZATION: _____
DBA, if any: _____
ADDRESS: _____
CITY: _____ STATE: ____ ZIP CODE:_____

CONTACT PERSON NAME: _____
TELEPHONE NUMBER: _____

CONTRACT NO's.: H _____; H _____; H _____; H _____
(If known)
TIN/EIN NAME of business for tax purposes (as registered with the IRS: a W-9 may be required) _____
EMPLOYER/TAX IDENTIFICATION NUMBER (EIN or TIN): _____
Mailing address for 1099 tax form:
STR1: _____
STR2: _____
CITY: _____
STATE: ____ ZIP: _____ - ____

FINANCIAL INSTITUTION
NAME OF BANK: _____
ADDRESS: _____
CITY: _____ STATE: ___ ZIP CODE: _____ - ____

ACH/EFT COORDINATOR NAME: _____
TELEPHONE NUMBER: _____
NINE DIGIT ROUTING TRANSIT (ABA) NUMBER: _____
DEPOSITOR ACCOUNT TITLE: _____
DEPOSITOR ACCOUNT NUMBER: _____
CIRCLE ACCOUNT TYPE: CHECKING SAVINGS (Please attach a copy of a voided check)
SIGNATURE & TITLE OF ORGANIZATION'S AUTHORIZED REPRESENTATIVE:

_____Date: _____
Signature Title

_____ _____
Print Name Phone Number

ATTACHMENT I
BATCH ELIGIBILITY QUERY INSTRUCTIONS AND LAYOUTS

Contents

1. Introduction

The Batch Eligibility Query (BEQ) is a specific query service within the MBD (Medicare Beneficiary Database) Services that will be provided to the Plans.

The BEQ provides a vehicle for all Plans, regardless of type or size, to submit batches of individuals for timely prescription drug program eligibility determination.

The BEQ will be available to the Plans beginning 11/15/2005.

2. Plan to CMS / Batch Eligibility Query (BEQ) Request File

2a. Batch Eligibility Query (BEQ) Request File / Record Formats

A Plan will submit a BEQ Request File to CMS in the following Format.

Record: Batch Eligibility Query (BEQ) Request Header Record

From: Plan To: CMS

Data Field	Length	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	"MMABEQRH"	Critical Field This field should always be set to the value " MMABEQRH". This code allows recognition of the record as the Header Record of a Batch Eligibility Query Request File. This field allows for the identification of the file as a Batch Eligibility Query (BEQ) Request File.
Sending Entity (CMS)	8	9 … 16	X(8)	Sending PDP(8) or HL(5)+3 Spaces	Critical Field HL(5) + 3 Spaces = H-Number only (Plan not identified) PDP(8) = H-Number with 3-position Plan identifier This field provides CMS with the identification of the entity that is sending the BEQ Request File. The value for this field will be provided to CMS and used in connection with CMS electronic routing and mailbox functions. The value in this field should agree with the corresponding value in the Trailer Record.
File Creation Date	8	17 … 24	X(8)	YYYYMMDD	Critical Field The date on which the BEQ Request File was created by the Sending Entity (Plan). This value should be formulated as YYYYMMDD. For example, January 3 2010 would be the value 20100103. This value should agree with the corresponding value in the Trailer Record. CMS will pass this information back to the Sending Entity (Plan) on all Transactions (Detail Records) of a BEQ Response File.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity (CMS)	Critical Field The specific Control Number assigned by the Sending Entity (Plan) to the BEQ Request File. CMS will pass this information back to the Sending Entity (Plan) on all Transactions (Detail Records) of a BEQ Response File. This value should agree with the corresponding value in the Trailer Record.
FILLER	717	34 … 750	X(717)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

Record: Batch Eligibility Query (BEQ) Request Trailer Record

From: Plan To: CMS

Data Field	Length	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	"MMABEQRT"	Critical Field This field should always be set to the value " MMABEQRT ". This code allows recognition of the record as the Trailer Record of a BEQ Request File. This field allows for the identification of the file as a Batch Eligibility Query (BEQ) Request File.
Sending Entity (CMS)	8	9 … 16	X(8)	Sending PDP(8) or HL(5)+3 Spaces	Critical Field HL(5) + 3 Spaces = H-Number only (Plan not identified) PDP(8) = H-Number with 3-position Plan identifier This field provides CMS with the identification of the entity that is sending the BEQ Request File. The value for this field will be provided to CMS and used in connection with CMS electronic routing and mailbox functions. The value in this field should agree with the corresponding value in the Header Record.
File Creation Date	8	17 … 24	X(8)	YYYYMMDD	Critical Field The date on which the BEQ Request File was created by the Sending Entity (Plan). This value should be formulated as YYYYMMDD. For example, January 3 2010 would be the value 20100103. This value should agree with the corresponding value in the Header Record. CMS will pass this information back to the Sending Entity (Plan) on all Transactions (Detail Records) of a BEQ Response File.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity	Critical Field The specific Control Number assigned by the Sending Entity (Plan) to the BEQ Request File. CMS will pass this information back to the Sending Entity (Plan) on all Transactions (Detail Records) of a BEQ Response File. This value should agree with the corresponding value in the Header Record.
Record Count	7	34 … 40	9(7)	Numeric value greater than Zero.	Critical Field The total number of Transactions (Detail Records) supplied on the BEQ Request File. This value should be right-justified in the field, with leading zeros. This value should not include non-numeric characters, such as commas, spaces, dashes, decimals.
FILLER	710	41 … 750	X(710)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

Record: Batch Eligibility Query (BEQ) Request
Detail Record (Transaction)

From: Plan To: CMS

Data Field	Length	Position	Format	Valid Values	Field Definition
Record Type	5	1 ... 5	X(5)	"DTL01" = Batch Eligibility Query Transaction Note: The value above is DTL-zero-one.	Critical Field This field should be set to the value "01," which indicates that this detail record is a Batch Eligibility Query Transaction. This code allows recognition of the detail record to be processed specifically for Batch Eligibility Query Service.
HICN/RRB Number	12	6 ... 17	X(12)	Health Insurance Claim Number or Railroad Retirement Board Number	Critical Field: This is a required field, if the SSN is not provided. This field provides either the Health Insurance Claim Number or the Railroad Retirement Board Number for identification of the individual. The Plan should provide either the HICN or the RRB Number, whichever the Plan has available and active for the individual. The value should be left-justified in the field. The value should not include dashes, decimals, or commas.
SSN	9	18 ... 26	X(9)	Social Security Number. Nine-Byte Numeric.	Critical Field: This is a required field, if the HICN/RRB is not provided. The Social Security Number for the individual. The value should include only numbers. The value should not include dashes, decimals, or commas.
Date of Birth (DOB)	8	27 ... 34	X(8)	YYYYMMDD	Critical Field The date of birth of the individual. The value should be formatted as YYYYMMDD. The value should not include dashes, decimals, or commas. The value should include only numbers.
Gender Code	1	35 ... 35	X(1)	0 (Zero) = Unknown; 1 = Male; 2 = Female	Not Critical Field The gender of the individual. The acceptable values include 0 (Zero) = Unknown, 1 = Male, 2 = Female.
Detail Record Sequence Number	7	36 ... 42	9(7)	Seven-byte number unique within the Batch Eligibility Query Request File	Critical Field A unique number assigned by the Sending Entity to the Transaction (Detail Record). This number should uniquely identify the Transactions (Detail Record) within the Batch Eligibility Query Request File.
FILLER	708	43... 750	X(708)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

2b. Batch Eligibility Query (BEQ) Request Instructions

The Sending Entities (Plans) may submit one BEQ (Batch Eligibility Query) Request File to CMS during any CMS business day via Connect:Direct (NDM) or the Sterling Electronic Mailbox. There is not a minimum or maximum limit with respect to the number of BEQ Request Transactions. Each Detail Record of a BEQ Request File will be considered a BEQ "Transaction."

The BEQ Request Files should be formulated to the record formats and field definitions described in Section 2a. Batch Eligibility Query (BEQ) Request File / Record Formats. The BEQ Request Files should be in flat file structure and conform to CMS naming conventions.

The MBD will recognize BEQ Request Files by the information supplied in the Header and Trailer Records. Header Record information is considered critical as it will be used by CMS to track, control, formulate and route files and transactions through the MBD process and communicate responses back to the Sending Entities (Plans).

The Transactions (Detail Records) on the BEQ Request File should be formulated to identify a prospective Plan enrollee. The Sending Entities (Plans) should not submit Transactions for individuals who have not requested consideration for enrollment.

The Sending Entities (Plans) should utilize the following naming standard for a Batch Eligibility Query (BEQ) Request file:

***P*#MBD.#BEQR.xxxxxxxx.IN.QUERY.NDM**

The Placeholder "xxxxxxxx" would be the Sending Entity Name. For definition of Sending Entity Name, please see Section 2a. Batch Eligibility Query (BEQ) Request File / Record Formats. If the Sending Entity Name is five characters in length, then the Placeholder value should also be five characters in length. Spaces should not be included in the file name.

The MBD will generate one Batch Eligibility Query (BEQ) Response File for a Sending Entity during a regular business day. This BEQ Response File will include all BEQ Request Transactions (Detail Records) processed by the MBD for the Sending Entity during that regular business day.

1. The BEQ Response File received by a Sending Entity may not include all BEQ Request Transactions provided to CMS during that regular business day.
2. The BEQ Response File received by a Sending Entity may include BEQ Request Transactions provided to CMS during the previous regular business day.
3. Any BEQ Request Transactions that have not been provided on the BEQ Response file will appear in the subsequent BEQ Response File for the following regular business day.

For example, if a Sending Entity submits one BEQ Request File within one day, it is possible that the Transactions (Detail Records) returned in the BEQ Response File will be for only a portion of the BEQ Request File submitted. In addition, the Transactions (Detail Records) absent from the BEQ Response File may be related to a BEQ Request File submitted by the Sending Entity during the previous CMS business day. The "Detail Record Sequence Number" located in each Transaction (Detail Record) can be used by the Sending Entity to track individual Transactions sent to and received from CMS.

3. CMS to Plans / Batch Eligibility Query (BEQ) Response File

3a. Batch Eligibility Query (BEQ) Response File / Record Formats

CMS will send BEQ (Batch Eligibility Query) Response Files to Sending Entities in the following format. The BEQ Response Files will be flat files created as a result of processing the Transactions (Detail Records) of Accepted BEQ Request Files (See Section 2b. Batch Eligibility Query (BEQ) Request Instructions; Section 3b. Batch Eligibility Query (BEQ) Response Process).

Record: Batch Eligibility Query (BEQ) Response Header Record

From: CMS ***To: Plans***

Data Field	Length	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	"CMSBEQRH"	This field will always be set to the value "CMSBEQRH". This code allows recognition of the record as the Header Record of a BEQ Response File. This field allows for identification of the file as a Batch Eligibility Query (BEQ) Response File.
Sending Entity (CMS)	8	9 … 16	X(8)	"MBD " (MBD + 5 Spaces)	This field will always be set to the value "MBD ". The value specifically is MBD + 5 following Spaces. This value will agree with the corresponding value in the Trailer Record.
File Creation Date	8	17 … 24	X(8)	YYYYMMDD	The date on which the BEQ Response File was created by CMS. This value will be formulated as YYYYMMDD. For example, January 3 2010 would be the value 20100103. This value will agree with the corresponding value in the Trailer Record.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity (CMS)	The specific Control Number assigned by the MBD to the BEQ Response File. CMS will utilize this value to track the BEQ Response File through CMS processing and archive. This value will agree with the corresponding value in the Trailer Record.
FILLER	717	34 … 750	X(717)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

Record: Batch Eligibility Query (BEQ) Response Trailer Record

From: CMS ***To: Plans***

Data Field	Length	Position	Format	Valid Values	Field Definition
File ID Name	8	1 … 8	X(8)	"CMS4BEQRT"	This field will always be set to the value "CMS4BEQRT". This code allows recognition of the record as the Trailer Record of a Batch Eligibility Query (BEQ) Response File. This field allows for the identification of the file as a BEQ Response File.
Sending Entity (CMS)	8	9 … 16	X(8)	"MBD " (MBD + 5 Spaces)	This field will always be set to the value "MBD ". The value specifically is MBD + 5 following Spaces. This value will agree with the corresponding value in the Header Record.
File Creation Date	8	17 … 24	X(8)	YYYYMMDD	The date on which the BEQ Response File was created by CMS. This value will be formulated as YYYYMMDD. For example, January 3 2010 would be the value 20100103. This value will agree with the corresponding value in the Header Record.
File Control Number	9	25 … 33	X(9)	Assigned by Sending Entity (CMS)	The specific Control Number assigned by CMS to the BEQ Response File. CMS will utilize this value to track the BEQ Response File through CMS processing and archive. This value will agree with the corresponding value in the Header Record.
Record Count	7	34 … 40	9(7)	Numeric value greater than Zero.	The total number of Transactions (Detail Records) on the BEQ Response File. This value will be right-justified in the field, with leading zeros. This value will not include non-numeric characters, such as commas, spaces, dashes, decimals.
FILLER	710	41 … 500	X(710)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

Record: Batch Eligibility Query (BEQ) Response
Detail Record (Transaction)

(This record is produced for all Batch Eligibility Query (BEQ) Response Transactions received)

From: CMS To: Plan

Data Field	Length	Position	Format	Valid Values	Field Definition
Record Type	3	1 ... 3	X(3)	"DTL"	This field will be set to the value "DTL," which indicates that this is a detail record.
Original Detail Record	42	4 ... 43	X(42)	The first 42 positions of the original Transaction (Detail Record) supplied by the Sending Entity.	This field provides the meaningfully-populated area of the BEQ Request File Transaction (Detail Record). provided by the Sending Entity (Plan).
Processing Flag	1	46 ... 46	X(1)	"Y" = The detail record processed successfully. "N" = The detail record did not process.	A flag that indicates whether or not the beneficiary was successfully processed for the Batch Eligibility Query (i.e. the Transaction processed successfully).
Beneficiary Match Flag	1	47 ... 47	X(1)	"Y" = The beneficiary was matched (located) successfully. "N" = The beneficiary was not matched (located) successfully.	A flag that indicates whether or not the beneficiary in the Transaction (Detail Record) was successfully matched (located) to a beneficiary on the CMS Medicare Beneficiary Database (MBD).
Medicare Part A Entitlement Start Date	8	48 ... 55	X(8)	YYYYMMDD	The Entitlement Start Date of the beneficiary's most recent or active Medicare Part A entitlement period.
Medicare Part A Entitlement End Date	8	56 ... 63	X(8)	YYYYMMDD	The Entitlement End Date of the beneficiary's most recent or active Medicare Part A entitlement period.
Medicare Part B Entitlement Start Date	8	64 ... 71	X(8)	YYYYMMDD	The Entitlement Start Date of the beneficiary's most recent or active Medicare Part B entitlement period.
Medicare Part B Entitlement End Date	8	72 ... 79	X(8)	YYYYMMDD	The Entitlement End Date of the beneficiary's most recent or active Medicare Part B entitlement period.
Medicaid Indicator	1	80 ...80	X(1)	"0" = The beneficiary has no current or active Medicaid coverage;	An indicator of the presence of current Medicaid coverage for the beneficiary:

Data Field	Length	Position	Format	Valid Values	Field Definition
				"1" = The beneficiary has current or active Medicaid coverage.	
Employer Subsidy Start Date (Occurrence 1)	8	81... 88	X(8)	YYYYMMDD	The Start Date of the First Occurrence (Most Recent or Presently Active) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy End Date (Occurrence 1)	8	89 ... 96	X(8)	YYYYMMDD	The End Date of the First Occurrence (Most Recent or Presently Active) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy Start Date (Occurrence 2)	8	97 ... 104	X(8)	YYYYMMDD	The Start Date of the Second Occurrence (Second Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy End Date (Occurrence 2)	8	105 ... 112	X(8)	YYYYMMDD	The End Date of the Second Occurrence (Second Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy Start Date (Occurrence 3)	8	113 ... 120	X(8)	YYYYMMDD	The Start Date of the Third Occurrence (Third Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy End Date (Occurrence 3)	8	121 ... 128	X(8)	YYYYMMDD	The End Date of the Third Occurrence (Third Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy Start Date (Occurrence 4)	8	129 ...136	X(8)	YYYYMMDD	The Start Date of the Fourth Occurrence (Fourth Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy End Date (Occurrence 4)	8	137 ... 144	X(8)	YYYYMMDD	The End Date of the Fourth Occurrence (Fourth Most Recent) of Employer Subsidy coverage for the

Data Field	Length	Position	Format	Valid Values	Field Definition
					beneficiary.
Employer Subsidy Start Date (Occurrence 5)	8	145 ... 152	X(8)	YYYYMMDD	The Start Date of the Fifth Occurrence (Fifth Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy End Date (Occurrence 5)	8	153 ... 160	X(8)	YYYYMMDD	The End Date of the Fifth Occurrence (Fifth Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy Start Date (Occurrence 6)	8	161 ... 168	X(8)	YYYYMMDD	The Start Date of the Sixth Occurrence (Sixth Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy End Date (Occurrence 6)	8	169 ... 176	X(8)	YYYYMMDD	The End Date of the Sixth Occurrence (Sixth Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy Start Date (Occurrence 7)	8	177 ... 184	X(8)	YYYYMMDD	The Start Date of the Seventh Occurrence (Seventh Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy End Date (Occurrence 7)	8	185 ... 192	X(8)	YYYYMMDD	The End Date of the Seventh Occurrence (Seventh Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy Start Date (Occurrence 8)	8	193 ... 200	X(8)	YYYYMMDD	The Start Date of the Eighth Occurrence (Eighth Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy End Date (Occurrence 8)	8	201 ... 208	X(8)	YYYYMMDD	The End Date of the Eighth Occurrence (Eighth Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy Start Date (Occurrence 9)	8	209 ... 216	X(8)	YYYYMMDD	The Start Date of the Ninth Occurrence (Ninth Most

Data Field	Length	Position	Format	Valid Values	Field Definition
					Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy End Date (Occurrence 9)	8	217 ... 224	X(8)	YYYYMMDD	The End Date of the Ninth Occurrence (Ninth Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy Start Date (Occurrence 10)	8	225 ... 232	X(8)	YYYYMMDD	The Start Date of the Tenth Occurrence (Tenth Most Recent) of Employer Subsidy coverage for the beneficiary.
Employer Subsidy End Date (Occurrence 10)	8	233 ... 240	X(8)	YYYYMMDD	The End Date of the Tenth Occurrence (Tenth Most Recent) of Employer Subsidy coverage for the beneficiary.
Sending Entity	8	241 ... 248	X(8)	Sending PDP(8) or HL(5)+3 Spaces	The Sending Entity provided on the Header Record of the BEQ Request File in which the Transaction (Detail Record) was found.
File Control Number	9	249 ... 257	X(9)	Assigned by Sending Entity	The File Control Number provided by the Sending Entity on the Header record of the BEQ Request File in which the Transaction (Detail Record) was found.
File Creation Date	8	258 ... 265	X(8)	YYYYMMDD	The File Creation Date provided on the Header Record of the BEQ Request File in which the Transaction (Detail Record) was found.
FILLER	485	266 ... 750	X(485)	Spaces	No meaningful values are supplied in this field. This field will be set to SPACES and should not be referenced for meaningful information nor used to store meaningful information, unless specifically documented otherwise.
Total Length = 750					

3b. Batch Eligibility Query (BEQ) Response Process

The MBD will analyze a received Batch Eligibility Query (BEQ) Request File to determine if the BEQ Request file can be Accepted or if it must be Rejected. The Transactions (Detail Records) of an Accepted BEQ File will be processed and a Batch Eligibility Query (BEQ) Response File will be created as a result. If a BEQ Request File is Rejected, then a BEQ Response File will not be generated.

The MBD will determine if a BEQ Request File shall be Accepted or Rejected based upon the Request File Error Conditions as documented in Section 4a. Request File Error Conditions. Upon determining if a BEQ Request File is to be Accepted or Rejected, the MBD will generate an email acknowledgement of receipt conveying the outcome.

- If the Batch Eligibility Query (BEQ) Request File has been Accepted, the email notification shall inform the Sending Entity that the specific BEQ Request File has been Accepted and shall be processed.
- If the Batch Eligibility Query (BEQ) Request File has been Rejected, the email notification shall inform the Sending Entity of the first File Error Condition which had caused the BEQ Request File to be Rejected.

This email acknowledgement/notification will be issued to the Sending Entity.

The MBD shall process all Transactions (Detail Records) of an Accepted BEQ Request File. Each Transaction shall be uniquely identified and tracked throughout the MBD processing service by the combination of the Sending Entity Name, File Control Number, File Creation Date, and Detail Record Sequence Number as provided by the Sending Entity on the BEQ Request File. As documented in Section 3a, each Detail Record of the BEQ Response File maintains these four critical fields.

When the MBD processes a Transaction, the MBD first verifies that all critical data is provided and valid on the record (See Section 2a. Batch Eligibility Query (BEQ) Request File / Record Formats). The MBD then attempts to perform a Beneficiary Match, in which the beneficiary identifying fields on the Transaction are utilized to locate a single beneficiary on the MBD.

If the MBD ***successfully locates*** the beneficiary on the database tables, then the MBD will perform the following steps.

- Create a Detail Record to be returned to the Sending Entity (Plan) in a Batch Eligibility Query (BEQ) Response File as specified in Section 3a. Batch Eligibility Query (BEQ) Response File / Record Formats;
- Assign values to the Match Flag fields as defined in Section 3a; and
- Populate the additional Eligibility Query fields of the Response File Detail Record with MBD data for the beneficiary.

If the MBD is ***unsuccessful in locating*** the beneficiary on the database tables or the Batch Eligibility Query (BEQ) Request File Transaction contains one or more critical errors (e.g. a critical field is invalid), then the MBD will perform the following steps.

- Create a Detail Record to be returned to the Sending Entity (Plan) in a Batch Eligibility Query (BEQ) Response File as specified in Section 3a. Batch Eligibility Query (BEQ) Response File / Record Formats;
- Assign values to the Match Flag fields as defined in Section 3a; and
- Not Populate the additional Eligibility Query fields of the Response File Detail Record with MBD data for the beneficiary.

The MBD will utilize the following naming standard for the Batch Eligibility Query (BEQ) Request File:

***P#*MBD.#BEQR.xxxxxxxx.OUT.RSLTS**

The Placeholder "xxxxxxxx" will be set to the same value as the Sending Entity Name of the incoming BEQ Request File. If the Sending Entity Name is five characters in length, then the Placeholder value will also be five characters in length. Spaces will not be included in the file name.

The Batch Eligibility Query (BEQ) Response File will be issued to the Sending Entity in the same transmission mechanism that the Sending Entity had utilized to deliver the BEQ Request File to CMS. This mechanism may utilize either a T1 Connection with Connect;Direct (NDM), or the Sterling Electronic Mailbox.

4. Batch Eligibility Query (BEQ) Response File Error Condition Table

4a. Request File Error Conditions

The following table contains File Level Error information. File Level Errors represent conditions in which a Batch Eligibility Query (BEQ) Request File is Rejected and not processed.

SOURCE OF ERROR	ERROR MESSAGE	ERROR CONDITION
Header Record	The Header Record is missing.	● The Header Record is not provided on the file. ● The Header Record cannot be read. ● More than one Header Record is provided on the file.
	The Header Record is Invalid.	● The Header Record is incorrectly formatted. ● The Header Record contains invalid values. ● The Header Record contains Critical Fields which are not provided.
Trailer Record	The Trailer Record is missing.	● The Trailer Record is not provided on the file. ● The Trailer Record cannot be read. ● More than one Trailer Record is provided on the file.
	The Trailer Record is Invalid.	● The Trailer Record is incorrectly formatted. ● The Trailer Record contains invalid values. ● The Trailer Record contains Critical Fields which are not populated. ● The Record Count in the Trailer Record is more than 2 different from the actual number of Detail Records (Transactions) in the file.
File Content	The File has no Transactions.	● There are no Transactions (Detail Records) found in the file.