

California Clinical Data Project

PHARMACY DATA STANDARD FORMAT SPECIFICATIONS

Version 2.0

Last Revision Date: May 2, 2005

Field #	Field Name	Field Format	Field Length	Field Location	Definition of Field Value/Comments	Status
1	Health Plan Name	A/N	10	1-10	Name of Health Plan See endnote Field 1: Health Plan Name	R
2	Health Plan ID	A/N	10	11-20	Health Plan Identifier. For California, use Department of Managed Health Care assigned codes (see www.dmhc.ca.gov) See endnote Field 2: Health Plan ID	R
3	Batch Number	N	5	21-25	Identifier assigned by Process/Sender See endnote Field 3: Batch Number	R
4	Run Date	N	8	26-33	Date on which file/tape/disk was created. (CCYYMMDD)	R
5	Version/Release #	A/N	2	34-35	CALINX Version and Release Number 20= Ver. 2 Rel. 0	R
6	Submission Number	A/N	2	36-37	00= Original Submission 01= First resubmission, etc. See endnote Field 6: Submission Number	R
7	Action Code	A/N	2	38-39	00= Original Submission (New) 02= Correction/Adjustment to a previous batch 03= Deletion of a previous batch 05= Replacement of a previous batch (delete followed by add) See endnote Field 7: Action Code	R
8	Record Indicator	A/N	2	40-41	00= New record 01= Overwrite existing record 02= Delete existing record <i>Condition: Required if field 7, Action Code is "00" Original Submission</i> See endnote Field 8: Record Indicator	C
9	Recipient ID	A/N	10	42-51	ID of group to whom data is being sent (assigned by sender)	O
10	Patient ID	A/N	18	52-69	Identification Number assigned to	R

Status:

R = Required - Must be populated.

O = Optional- Does not need to be populated.

C = Conditional - May need to be populated based on status of related fields. See note on specific fields.

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					patient by Health Plan, as appearing in the pharmacy claim. See endnote Field 10: Patient ID	
11	Alternate Patient ID Qualifier	A/N	2	70-71	Alternate Patient ID Qualifier 00= Not Defined 01 = Non SSN-based Patient ID assigned by Health Plan 02= SSN-based Patient ID assigned by Health Plan 03= Patient SSN 99= Other <i>Condition: Required if field 12, Alternate Patient ID is populated.</i> See endnote Field 11: Alternate Patient ID Qualifier	C
12	Alternate Patient ID	A/N	18	72-89	Alternate Identification Number assigned to patient by Health Plan See endnote Field 12: Alternate Patient ID	O
13	Patient Last Name	A/N	15	90-104	Patient's last name	R
14	Patient First Name	A/N	12	105-116	Patient's first name	R
15	Date of Birth	N	8	117-124	Patient's Date of Birth CCYYMMDD format	R
16	Patient Gender	A/N	1	125-125	Patient's Gender 0= Not specified 1= Male 2= Female	R
17	Patient Relation	A/N	1	126-126	Patient's relationship to cardholder (insured) 0= Not specified 1= Cardholder 2= Spouse 3= Male child 4= Female child 5= Covered minor dependent of cardholder 6= Covered adult dependent (not spouse) 7= Previous spouse of cardholder 8= Not used 9= Other (not included above)	R
18	Patient Employer	A/N	15	127-141	ID code assigned to cardholder	O

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Field #	Field Name	Field Format	Field Length	Field Location	Definition of Field Value/Comments	Status
					employer group (by Health Plan)	
19	Date Rx Filled	N	8	142-149	Date the prescription was filled or service rendered (CCYYMMDD)	R
20	NDC	A/N	11	150-160	National Drug Code 11-digit format 5= Manufacturer 4= Product 2= Package Size See endnote Field 20: NDC	R
21	Label Name	A/N	30	161-190	Product or Service Description – Use name of medication as it appears on label. See endnote Field 21: Label Name	R
22	Alternate Product Code ID Qualifier	A/N	2	191-192	Alternate Product Code ID Qualifier 00= Not defined 01= GPI 02= AHFS 03= GCN 04= SMART Key 97= Trading Partner Defined 99= Other <i>Condition: Required if field 23, Alternate Product ID is populated.</i>	C
23	Alternate Product ID	A/N	18	193-210	Alternate Product ID Code	O
24	Generic Name	A/N	30	211-240	Name of Generic equivalent See endnote Field 24: Generic Name	O
25	Brand Name	A/N	30	241-270	Drug Brand Name See endnote Field 25: Brand Name	O
26	Strength	A/N	8	271-278	Drug product strength (value and units)	O
27	Dosage Form	A/N	8	279-286	Dosage form for product dispensed	O
28	Route of Administration	A/N	8	287-294	Route of administration of product See endnote Field 28: Route of Administration	O
29	Quantity Dispensed	SD	11	295-305	Metric Decimal quantity of product dispensed (9999999v999S)	R
30	Days Supply	SN	4	306-309	Estimated number of days the	R

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Field #	Field Name	Field Format	Field Length	Field Location	Definition of Field Value/Comments	Status
					prescription will last (999S)	
31	New/Refill Indicator	A/N	2	310-311	00= New 01= Refill	R
32	Refill Number	N	2	312-313	0= Unknown 1-99= Refill Number <i>Condition: Required if field 31, New Refill Indicator = 01.</i> See endnote Field 32: Refill Number	C
33	Prescription #	A/N	7	314-320	Number assigned by pharmacy to transaction provided	R
34	Drug Type	A/N	1	321-321	Drug Type <i>as defined by Health Plan:</i> 0= Not specified 1= Single source brand 2= Branded generic cross licensed brand 3= Generic 4= OTC 5= Multi-source brand (branded drug with generic available) See endnote Field 34: Drug Type	R
35	Formulary status	A/N	1	322-322	Y= Yes N= No Z= Unknown or not classified	O
36	Pharmacy ID_Chain Code	A/N	5	323-327	ID assigned by NCPDP to a chain See endnote Field 36: Pharmacy ID_Chain Code	O

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Field #	Field Name	Field Format	Field Length	Field Location	Definition of Field Value/Comments	Status
37	Pharmacy ID_NCPDP Code	A/N	7	328-334	Individual pharmacy identification assigned by NCPDP See endnote Field 37: Pharmacy ID_NCPDP Code	O
38	Place of service	A/N	2	335-336	00= Not specified 01= Home 02= inter-care 03= nursing care 04= long-term care 05= rest home 06= boarding home 07= skilled care facility 08= sub-acute care facility 09= acute -care facility 10= Outpatient/Ambulatory 11= hospice 99= Other - not included in above	O
39	Date Billed	N	8	337-344	Ending date of financial period CCYYMMDD	O
40	Co-pay amount	SD	8	345-352	Amount paid by patient \$\$\$\$ccS See endnote Field 40: Co-pay Amount	R
41	Net Amount Due	SD	8	353-360	Amount paid to pharmacy (net cost to plan) \$\$\$\$ccS See endnote Field 41: Net Amount Due	R
42	Ingredient Cost	SD	8	361-368	Drug Ingredient Cost included in total amount due \$\$\$\$ccS See endnote Field 42: Ingredient Cost	R
43	Product Type	A/N	4	369-372	Insurance Product Type, as specified by the Health Plan (Line of Business Code). This field may not be consistently populated across health plans. See also Field 56: Product Line Category Code. See endnote Field 43: Product Type	R
44	Claim Number	A/N	15	373-387	Unique claim identification number assigned by Health Plan or the ID number on the original claim.	R
45	Payment Status	A/N	1	388-388	0= Paid	R

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Field #	Field Name	Field Format	Field Length	Field Location	Definition of Field Value/Comments	Status
					1= Reversed See endnote Field 45: Payment Status	
46	Prescriber ID Qualifier	A/N	2	389-390	00= Not defined 01= DEA # 02= State License # 03= National Prescriber ID # 04= Tax ID # 05= SS # 06= HIN # 07= Health Plan assigned # 99= Other See endnote Field 46 : Prescriber ID Qualifier	R
47	Prescriber ID	A/N	18	391-408	ID assigned to prescriber (in form defined by qualifier)	R
48	Provider Last Name	A/N	15	409-423	Last Name of prescribing provider	O
49	Provider First Name	A/N	12	424-435	First name of prescribing provider (or initial)	O
50	PCP ID Qualifier	A/N	2	436-437	00= Not defined 01= DEA # 02= State License # 03= National Prescriber ID # 04= Tax ID # 05= SS # 06= HIN # 07= Health Plan Assigned ID# 99= Other <i>Condition: Required if field 51 "PCP ID Code" is populated.</i> See endnote Field 50: PCP ID Qualifier	C
51	PCP ID	A/N	18	438-455	ID assigned to the patient's primary care provider (in form defined by qualifier in Field #50)	O
52	PCP Last Name	A/N	15	456-470	Last Name of Primary Care Provider	O
53	PCP First Name	A/N	15	471-485	First Name of Primary Care Provider	O
54	Provider group	A/N	14	486-499	ID assigned to patient's medical group <i>Condition: Required if Field 56 "Product Line Category Code" is 1-6 (i.e., if prescription is for a managed-</i>	C

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Field #	Field Name	Field Format	Field Length	Field Location	Definition of Field Value/Comments	Status
					care patient)	
55	PSC/DAW	A/N	1	500-500	Product Selection Code/Dispense as Written (0-9) 0= No product selection indicated 1= Substitution not allowed by prescriber 2= Substitution allowed-patient requested product dispensed 3= Substitution allowed-pharmacist selected product dispensed 4= Substitution allowed-generic drug not in stock 5= Substitution allowed-brand drug dispensed as a generic 6= Override 7= Substitution not allowed-brand drug mandated by law 8= Substitution allowed-generic drug not available in market place 9= Payor defined exemption	O
56	Product Line Category Code	A/N	1	501-501	0- Unknown 1- Commercial (HMO/POS) 2- Medicare Risk 3- Senior - Other 4- MediCal 5- Healthy Families 6- Other Government	R
57	Blank	A/N	30	502-531	Reserved for future expansion by CALINX See endnote Field 57: Blank	O
58	Filler	A/N	81	532-612	Used for additional data specific to trading partners See endnote Field 58: Filler	O

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End Notes for Select Fields

Field 1: Health Plan Name

The Health Plan Name is the text name of the health plan sending the data. It is self-assigned by the health plan and does not necessarily conform to any consistent naming standards.

Field 2: Health Plan ID

This field is a unique identifier of the Health Plan sending the data. For reporting specific to California, use Department of Managed Health Care assigned codes (www.dmhc.ca.gov). These are 4-digit codes assigned by the DMHC for health insurance companies operating in California. If this standard is used in other states or across states to report pharmacy claims activity, please use an appropriate standard identifier, as agreed-upon by all sending and receiving parties.

Field 3: Batch Number

All records in a data set should have the same batch number. The batch number should be unique for a given health plan or other sender of pharmacy claims data (e.g., PBM). The batch number should only be reused to tie a replacement, changed or deleted record back to the original batch (see endnote for [Field 5: Submission Number](#) for more information). Many health plans use the “Julian” representation of the report date (i.e., YYDDD) as the batch number, but this is not required.

Field 6: Submission Number

The submission number is a two digit code that indicates the number of times a data set has been resent (for example, due to errors). All records in the data set should have the same submission number. Subsequent recreations of the same data set (“resubmissions”) should have the previous submission number increased by 1. Note: The batch number (Field 2) in any resubmission should be the same and the same batch number in the original submission. Maintaining the same batch number across submissions and resubmissions will help organizations identify records that need to be corrected or replaced when resubmissions are sent.

Field 7: Action Code

The action code is a two- digit code that instructs the receiver of the data set as to how the data is to be processed. The values are defined as follows:

- **00 = Original Submission (New)** - represents an original or 'new' batch submission. This code is used in most cases.
- **02 =Correction/Adjustment to previous batch** - represents a correction or adjustment to specific records sent in a previous corresponding batch. The record or records that are sent with an '02' Action Code in this batch should replace the corresponding records in the previous batch.
- **03=Deletion of previous batch** - represents a deletion of an entire previously sent batch. If an '03' is sent, all records sent in the previous corresponding batch should be deleted.

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- **05=Replacement of previous batch (delete followed by add)** - represents a full replacement of a previous batch. If an '05' is sent, all records sent in the previous corresponding batch should be deleted and replaced with all records sent in this batch.

Note that a record with a submission number of '00' can only have an action code of '00'. A record with a submission number of '01' or greater cannot have an action code of '00'. A record with an action code of '01' or greater cannot have a submission number of '00.' If the action code is not '00', the sender should alert the receiver to ensure correct processing.

Field 8: Record Indicator

Use of this field is reserved for the case when an original submission is sent (Action Code = 00), and the batch includes a small number of corrections/deletions to previously sent records. This field allows data to be flagged on a record-by-record basis so that the receiving organization can understand what action to take on each record. This field is conditional, and should be populated only if the Action Code (Field 7) is "00" (Original Submission). The allowed values are:

- **00 = New Record** - Insert new record (this value should be assigned to most records in an original submission, i.e. those records that represent new data and are *not* corrections/additions to previously sent records)
- **01 = Overwrite existing record** – An error was discovered in a previously sent version of this record; therefore the receiver should delete the previously sent version and replace it with this record. Note: The previously sent version may be identified by the Health Plan ID, Claim Number, Prescription #, and Payment Status.
- **02 = Delete existing record** – This record was previously sent in error; therefore the receiver should delete the previously sent version of this record. There is no corresponding replacement record

Please NOTE: Claim reversals should be treated as New Records. When a claim is reversed, Payment Status (Field 45) should = "1" and Record Indicator should = "00" to allow for the dollar and quantity amounts to be correctly negated.

Field 10: Patient ID

This field is the health plan assigned ID of the patient as it appears in the pharmacy claim. This field does not use a qualifier because there is no industry wide coding standard to represent member/patient identification.

Field 11: Alternate Patient ID Qualifier

This field contains a two-digit code describing the type of identifier in the Alternate Patient ID field that follows. It is a conditional field and must be populated if and only if there is an Alternate Patient ID included in the record. Alternative IDs are sometimes used by the health plan as an additional way to identify the patient. Explanations of each type follow:

00 - Not Defined: Type of ID is unknown.

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01 - Non SSN-based Patient ID assigned by Health Plan: This is the “new” identifier assigned by health plans to replace any previous identifier that may have included the subscriber’s social security number. Sample: J57889394948 (a meaningless number)

02 - SSN-based Patient ID assigned by Health Plan: This is the “old” identifier previously used by many health plans, which includes the subscriber’s social security number. Sample: XJK164328843-01 (if the subscriber’s SSN is 164328843)

03 - Patient SSN: The patient’s actual SSN: Sample: 164328843 (from above)

99 - Other: Type of ID not among listed options.

Field 12: Alternate Patient ID

This field represents the alternate IDs that are sometimes used by the health plan to identify the patient. These IDs vary by health plan and can be proprietary, SSN-based, or be the patient's SSN (see Field 11).

Field 20: NDC

This field is the eleven digit National Drug Code (NDC). The eleven digits represent: manufacturer (5), product (4), and package size (2).

Field 21: Label Name

The medication name as it appears on the label should be populated in this field. Label name includes “drug name, strength (value & units) and dosage form”.

Field 24: Generic Drug Name

This field should be populated with the generic equivalent (except for compounded drugs and non-drug items in which case this field will be left blank). Please note that for compounded drugs, the field should be populated, if possible, with the generic name of the most prominent ingredient.

Field 25: Brand Name

This field should be populated with the brand name of the drug. This field is blank filled if the medication is a generic drug.

Field 28: Route of Administration

There are no established standard values for this field. For analytic purposes, the route of administration may be derived through the use of the NDC code and a reference drug database.

Field 32: Refill Number

This field represents the sequence number of the refill (if known). For example, 01=the first refill, 02=the second refill, etc. If the prescription is a refill, but the sequence number is unknown, 00

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should be used. If the prescription is not a refill (i.e., if Field 31 = "00"), then this field should be left blank.

Field 34: Drug Type

Health plans generally use this field to report how the drug is classified *for payment purposes*. This field does not necessarily report the actual brand/generic status of the drug. For example, it is possible that a brand drug may be reported as generic in this field, if the drug has a favorable status on the health plan formulary. If an organization wants to know the *actual* brand/generic status of the prescribed medication, this information may be referenced from a proprietary drug database via the reported NDC code (Field 20).

Field 36: Pharmacy ID Chain Code

Field 37: Pharmacy ID NCPDP Code

The codes contained in fields 36 and 37 are proprietary to the National Council for Prescription Drug Programs (NCPDP). Organizations that send these codes in Calinx Rx 2.0 messages and organizations that receive and use these codes must license the NCPDP standard data dictionary. Please refer to www.ncdp.org for information about licensing NCPDP standards.

Field 40: Co-pay Amount

The co-pay amount represents the portion of the total claim amount paid by the member or the patient.

Field 41: Net Amount Due

The net amount due represents the dollar amount paid by the health plan to the pharmacy. The formula for calculating this field is; Net Amount Due = Ingredient Cost + Dispensing Fee + Sales Tax - Co-Pay - Deductible

Field 42: Ingredient Cost

The ingredient cost field represents that portion of the total payment that is assigned specifically to the product or service and is independent of any professional fee or tax.

Field 43: Product Type

This field represents the member's insurance plan type, as specified by the health plan. Examples include "Commercial," "Medicare," etc. It is included because financial budgets are often based on this value. Note that the values in this field are not necessarily consistent across health plans (i.e., health plans may use different values to represent the same product types). For consistently coded product types, see Field 56: Product Line Category Code. Product Type is included for backward compatibility only.

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Field 45: Payment Status

There are times when a prescription is filled and initially billed by the pharmacy, but subsequently the prescription is not picked up by the patient or is returned to stock for another reason. When this type of event occurs, the claim is 'reversed' by the pharmacy, and the reported payment status = 1 for that record. In these cases, the quantity field and all currency fields should be negative (see below).

The standard specification is designed to accommodate claims and subsequent reversals through the use of the Claim #, the Payment Status, and the related financial fields, as described below. An example of how to encode claims and reversals follows:

Initial transmission (initial claim):

Unique claim # assigned to prescription, for example: 99999999999999
Payment status is 'paid' = '0'
Date script filled: 20040101
Ingredient cost: Sign is Positive (b)
Quantity dispensed: Sign is Positive (b)
CoPay amount: Sign is Positive (b)
Days supplied: Sign is Positive (b)
Net amount due: Sign is Positive (b)

Reversal ("cancellation" of claim by pharmacy):

Same unique claim # for prescription, for example: 99999999999999
Payment status is 'Reversed' = '1'
Date script filled is same: 20040101
Ingredient cost: Sign is Negative (-), magnitude is same as in initial claim
Quantity dispensed: Sign is Negative (-), magnitude is same as in initial claim
CoPay amount: Sign is Negative (-), magnitude is same as in initial claim
Days supplied: Sign is Negative (-), magnitude is same as in initial claim
Net amount due: Sign is Negative (-), magnitude is same as in initial claim

Re-transmission, if any (submission of new claim for the same prescription):

New unique claim # for script, example: 88888888888888
Payment status is 'paid' = '0'
Date script filled may be different: 20040102
Ingredient cost: Sign is Positive (b)
Quantity dispensed: Sign is Positive (b)
CoPay amount: Sign is Positive (b)
Days supplied: Sign is Positive (b)
Net amount due: Sign is Positive (b)

Some health plans "cancel out" (delete) claims and reversal records in their database if both are entered during the same reporting period. In this case, neither record appears in the data reported to the provider organizations, which is fine. However, if a claim is reported in one reporting period and later reversed in a subsequent reporting period, the two records should not be deleted. It is important that the reversal be retained and sent for the appropriate reporting period, so that the provider organization can accurately reconcile it with the claim that was reported earlier

Field 46: Prescriber ID Qualifier

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Since there are several coding schemes available to identify providers, a qualifier code is included to inform the receiver what coding scheme is being used to identify the prescriber.

Qualifiers include:

- **00=Not defined** – Type of ID is unknown
- **01=DEA #** - Unique number assigned by the Drug Enforcement Agency to prescribing clinicians. If a plan does not have a DEA number (a rare occurrence), they may populate this with a dummy DEA number (see Note below).
- **02=State License #**
- **03=National Prescriber ID #**
- **04=Tax ID #**
- **05=SS #** - Social Security Number
- **06=HIN # - The Health Industry Number (HIN)** is a unique identifier for enumerating services and activities throughout the health industry. The HIN enumerates prescribers by location, provider establishments and all other entities in the health industry supply chain. The HIN Database is maintained by the Health Industry Business Communications Council (HIBCC)
- **07=Health Plan assigned #** - ID assigned and maintained by health plan
- **99=Other** – Type of ID not included in the above

Note that in certain cases, a “dummy” (invalid) DEA# may be transmitted from the pharmacy to the health plan (for example, when the prescriber has no DEA# or the DEA# is unknown). In these cases, the prescriber ID received by the health plan will be formatted identically as a valid DEA#, and the health plan will be unable to distinguish it from a valid DEA#. Therefore, the health plan will encode the prescriber ID as a DEA # in this field (value “01”), although the identifier may not be valid.

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Field 50: PCP ID Qualifier

Since there are several coding schemes available to identify providers, a qualifier code is included to inform the receiver what coding scheme is being used to identify the PCP.

Qualifiers include:

- **00=Not defined** – Type of ID is unknown
- **01=DEA #** - Unique number assigned by the Drug Enforcement Agency to prescribing clinicians.
- **02=State License #**
- **03=National Prescriber ID #**
- **04=Tax ID #**
- **05=SS #** - Social Security Number
- **06=HIN #** - **The Health Industry Number (HIN)** is a unique identifier for enumerating services and activities throughout the health industry. The HIN enumerates prescribers by location, provider establishments and all other entities in the health industry supply chain. The HIN Database is maintained by the Health Industry Business Communications Council (HIBCC)
- **07=Health Plan assigned #** - ID assigned and maintained by health plan
- **99=Other** – Type of ID not included in the above

Field 57: Blank

This field is reserved for future expansion of the CALINX standard.

Field 58 - Filler

This field is blank filler and is intended for custom use by individual trading partners. Use of this space by trading partners will not be affected by future revisions of the format.

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Implementation Guide

Background and Purpose

Version 2.0 is based on Version 1.1 of the California Information Exchange (CALINX) Pharmacy Data Standard Format Specification published in January 2000. Version 2.0 represents an industry review of Version 1.1 and includes field updates and clarifications. The industry review included health plan, provider organization, and vendor participation. The review and regular maintenance of the specification is supported by the California HealthCare Foundation (CHCF). Questions and or comments regarding the specification and its implementation should be directed to the CHCF.

The implementation guide is a reference document to ensure consistent implementation of the standard format by health plans and/or their agents and consistent interpretation of the standard format by physician organizations in California. The implementation guide provides directions and instructions for the health plan and/or PBM agent for the creation of the data specification and for the medical group/provider organization in the interpretation and use of the data.

Out of Scope

The specific use of optional fields by trading partners is not addressed in the standard specification of the implementation guide. Use of these fields should be defined by contract terms between trading partners. The inclusion of optional fields should not be interpreted as a recommendation for their use. Contract negotiations and maintenance of contract terms are not addressed in the standard.

Data Guidelines

- The flat file format is designed for use on a main frame, mid-range or PC/LAN computer system.
 - Records are fixed length. Fields are fixed-width and NOT delimited.
 - To signify the end of a record and the beginning of the next record within a file, a standard delimiter (carriage return + line feed) is used.
 - Each record within a file has a header section that applies to the entire data file (i.e., the values of the fields in the header section should be the same for all records). The header portion of the record identifies the sender, the receiver, the date the file was created, and other general information.
 - All multiple configuration fields have a qualifier
- All dates are represented as 8 digits, following the format: CCYYMMDD. For example, June. 8, 2004 is represented as "20040608"
- Field formats are either *Numeric*, *Alphanumeric*, *Signed Decimal*, or *Signed Numeric* and are defined as follows:
 - **Numeric (N)** fields are right justified and zero filled. They may contain only the digits 0 – 9. Zero is a valid value and does not mean 'not reported'. If there is no value for a Numeric field, the entire field should be blank filled.

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- **Alphanumeric (A/N)** fields are left justified and blank filled. They may contain only the characters 0-9, a-z, A-Z, or other printable ASCII character. If no value is available, the entire field should be blank filled.
- **Signed Decimal (SD)** fields are right justified and zero filled. They are often used for currency values or quantities. They may contain only the digits 0-9, plus the “space” character (ASCII 32) or the “minus” character (ASCII 45) in the right-most position to denote a positive or negative value, respectively. It is important to highlight that positive values are *NOT* denoted with the “plus” character (+). Positive values are denoted by a “space” character (ASCII 32).

SD fields use implied decimal positioning, such that the position of the decimal point is specified in a character mask that is defined for each Signed Decimal field. For example, the mask "99999v99s" denotes that there is an implied decimal point three positions from the right, and a sign character in the right-most position. *Signed Decimal fields do not actually contain a decimal point.*

Some example values follow (note that for purpose of the example values, a space character (ASCII 32) character is denoted by the character “b”).

Example values:

<u>Field Length</u>	<u>Mask</u>	<u>Value</u>	<u>Meaning</u>
8	99999v99s	0015000b	\$150.00
6	999v99s	02550-	-\$25.50

- **Signed Numeric (SN)** fields are right justified and zero filled. They may contain only the digits 0-9, plus the “space” character (ASCII 32) or the “minus” character (ASCII 45) in the right-most position to denote a positive or negative value, respectively. It is important to highlight that positive values are *NOT* denoted with the “plus” character (+). Positive values are denoted by a “space” character (ASCII 32).

Example values:

<u>Field Length</u>	<u>Value</u>	<u>Meaning</u>
4	010b	10
8	0000450-	-450

- Each field is designated with a field status of “R” (Required), “O” (Optional), or “C” (Conditional), defined as follows:
 - **Required** fields must be populated with a non-blank value for the record to be compliant with the standard.
 - **Optional** fields may be populated, but need not be. If an Optional field is populated, its value should conform to the standard specification for the field. Optional fields that do not contain data should be blank filled. For the purpose of this specification, zeros appearing in Numeric, Signed Numeric, and Signed Decimal fields are to be considered valid data.
 - **Conditional** fields may need to be populated based on the status of related fields. Comments accompanying each conditional field specify conditions under which the fields must be populated. If the conditions are met, the field must be populated (i.e., is Required).

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If the conditions are not met, the field should not be populated (i.e., it should be blank filled).

- ID Code Qualifier fields are used to eliminate the need for creating individual fields for all possible value types. For example, see Field 42 - Prescriber ID Qualifier. The prescriber may be identified by either the HIN number, the DEA number, TAX ID number or other agreed upon code. In general, the qualifier field is used to indicate to the recipient what type of code is being submitted in the corresponding field. Qualifier fields are Conditional and only required if data is supplied in the accompanying ID Code field.
- Many coded fields include values for "Other" and/or "Not Defined". "Other" denotes any type of code that is not enumerated in the provided list of codes. "Not defined" denotes that the reporting party did not indicate the type of code being supplied.