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| **CPCDS Data Dictionary**  **Claim – Medical** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 90, 118 | Claim Service Start Date | 90 - Date on which services began. UB04 (Form Locator 45).  118 - Date on which services began. Located on CMS 1500 (Form Locator 24A) |
| 119 | Claim Service End Date | Date on which services ended. Located on CMS 1500 (Form Locator 24A) |
| 107 | Claim Paid Date | The date the claim was paid. |
| 88 | Claim Received Date | The date the claim was received by the payer. |
| 18 | Member Admission Date | The date corresponding with admission of the beneficiary to a facility and the onset of services. May precede the Statement From Date if this claim is for a beneficiary who has been continuously under care. |
| 19 | Member Discharge Date | Date the beneficiary was discharged from the facility, or died. Matches the Statement Thru Date. When there is a discharge date, the Patient Discharge Status Code indicates the final disposition of the patient after discharge. |
| 109 | Patient Account Number | Provider submitted information that can be included on the claim. |
| 110 | Medical Record Number | Provider submitted information that can be included on the claim. |
| 35 | Payer Claim Unique Identifier | Identifier assigned by a payer for a claim received from a provider or subscriber. It is not the same identifier as that assigned by a provider. |
| 111 | Claim Adjusted from Identifier | If the current claim represents a claim that has been adjusted and was given a prior claim number, this field represents the prior claim number |
| 112 | Claim Adjusted to Identifier | If the current claim has been adjusted; i.e., replaced by or merged to another claim number, this data element represents that new number. |
| 32 – Claim diagnosis related group (DRG) version  33- Claim diagnosis related group (DRG)  113 – Claim diagnosis related group (DRG) Name | Claim Diagnosis Related Group Version | 32 - Version of the DRG codes assigned for inpatient facility claims.  33- Claim diagnosis related group (DRG) code value  113 - Name of the DRG grouper assigned; i.e., MS-DRG, AP-DRG or APR-DRG |
| 13 | Claim Inpatient Source Admission Code | Identifies the place where the patient was identified as needing admission to a facility. This is a two position code mapped from the standard values for the UB-04 Source of Admission code (FL-15). |
| 14 | Claim Inpatient Admission Type Code | Priority of the admission. Information located on (UB04 Form Locator 14). For example, an admission type of elective indicates that the patient's condition permitted time for medical services to be scheduled. |
| 114 | Claim Bill Facility Type Code | UB04 (Form Locator 4) type of bill code provides specific information for payer purposes. The first digit of the three-digit number denotes the type of facility. |
| 115 | Claim Service Classification Type Code | UB04 (Form Locator 4) type of bill code provides specific information for payer purposes. The second digit classifies the type of care (service classification) being billed. |
| 116 | Claim Frequency Code | UB04 (Form Locator 4) type of bill code provides specific information for payer purposes. The third digit identifies the frequency of the bill for a specific course of treatment or inpatient confinement. |
| 140 | Claim Processing Status Code | Claim processing status code |
| 16 | Claim Type Code | Specifies the type of claim. (e.g., inpatient institutional, outpatient institutional, physician, etc.). |
| 15 | Claim Sub Type | High-level categorization of the claim. |
| 117 | Patient Discharge Status Code | Patient’s status as of the discharge date for a facility stay. Information located on UB04 (Form Locator 17). |
| 92 | Claim Payment Denial Code | Reason codes used to interpret the Non-Covered Amount that are provided to the Provider |
| 141 | Claim Primary Payer Identifier | Identifies the primary payer. For use only on secondary claims. |
| 120 | Claim Payee Type Code | Identifies the type of recipient of the adjudication amount; i.e., provider, subscriber, beneficiary or another recipient |
| 121 | Claim Payee | Recipient reference. |
| 91 | Claim Payment Status Code | Indicates whether the claim was paid or denied. |
| 2 | Claim Payer Identifier | The identifier assigned to the Operating Surgeon. |
| 177 | Statement From Date | On Institutional claims, the first day on the billing statement covering services rendered to the beneficiary (i.e. 'Statement Covers From Date’). On Professional and Non-Clinician claims, Earliest of any of the line-item level dates. It is almost always the same as Claim Service End Date except for DME claims - where some services are billed in advance. |
| 178 | Statement Thru Date | On Institutional claims, the last day on the billing statement covering services rendered to the beneficiary (i.e. 'Statement Covers Thru Date’)  On Professional and Non-Clinician claims, the latest of any of the line-item level dates. |
| 179 | Adjudication Date | Date the claim was adjudicated |
| 148 | Total Amount | Total amount for each category (i.e., submitted, eligible, etc.) |
| 183 | Claim Identifier Type | Indicates that the claim identifier is that assigned by a payer for a claim received from a provider or subscriber. |
| 187 | Procedure Code Type | Indicates if the inpatient institutional procedure (ICD-PCS) is the principal procedure or another procedure |
| 188 | Adjudication Amount Type | Describes the various amount fields used when payers receive and adjudicate a claim |

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| **CPCDS Data Dictionary**  **Claim - Retail Pharmacy** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 77 | Days Supply | Number of days supply of medication dispensed by the pharmacy. |
| 35 | RX Service Reference Number | Identifier assigned by a payer for a claim received from a provider or subscriber. It is not the same identifier as that assigned by a provider. This identifier assigned by the payer becomes the payer's EOB identifier. |
| 79 | DAW Product Selection Code | Prescriber's instruction regarding substitution of generic equivalents or order to dispense the specific prescribed medication. |
| 137 | Refill Number | The number fill of the current dispensed supply (0, 1, 2, etc.). |
| 143 | Prescription Origin Code | Whether the prescription was transmitted as an electronic prescription, by phone, by fax, or as a written paper copy |
| 144 | Plan Reported Brand-Generic Code | Whether the plan adjudicated the claim as a brand or generic drug. |
| 148 | Total Amount | Total amount for each category (i.e., submitted, eligible, etc.) |
| 183 | Claim Identifier Amount | Indicates that the claim identifier is that assigned by a payer for a claim received from a provider or subscriber. |
| 188 | Adjudication Amount Type | Describes the various amount fields used when payers receive and adjudicate a claim |

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| **CPCDS Data Dictionary**  **Claim / Claim Line - Dental** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 194 | Procedure Code - CDT | Dental procedure that a patient received from a health care provider. Current coding methods for reporting dental services are based on Current Dental Terminology, commonly known as CDT published by the American Dental Association (ADA). |
| 195 | Procedure Modifier Code - CDT | Modifier(s) for the dental procedure represented on this line. Identifies special circumstances related to the performance of the service. |
| 196 | Tooth Number - First Occurrence | Indicates the tooth notation i.e. the unique number or letter designated to the teeth, of the first occurrence. The values are based on the American Dental Association (ADA)'s Universal Numbering System/National Tooth Designation system for tooth numbers. (01 - 32 for permanent teeth; A – T for deciduous teeth). (01 - 32 for permanent teeth; A – T for deciduous teeth). |
| 197 | Tooth Surface | Indicates the specific areas of the teeth. This is based on the ADA's Universal standard mandated under HIPAA 837D. |
| 198 | Missing Tooth Number - First Occurrence | Indicates the first occurrence of the missing tooth number. The values are based on the American Dental Association (ADA)'s Universal Numbering System/National Tooth Designation system for tooth numbers. (01 - 32 for permanent teeth; A – T for deciduous teeth). (01 - 32 for permanent teeth; A – T for deciduous teeth). |
| 199 | Orthodontics Treatment Indicator | Indicates if the treatment is for orthodontics |
| 200 | Orthodontics Appliance Application Date | Date that the orthodontic appliances were placed. |
| 201 | Total Number of Months for Orthodontia | Number of months the orthodontia will remain in place. |
| 202 | Prosthesis Replacement Indicator | Indicate whether the services billed are for an oral prosthesis such as bridges, dentures, etc. |
| 203 | Date of Prior Prosthesis Placement | Identify the date when the prior prosthesis was placed. |
| 204 | Tooth Number - After First Occurrence | Indicates the tooth notation i.e. the unique number or letter designated to the teeth, for those after the first occurrence. The values are based on the American Dental Association (ADA)'s Universal Numbering System/National Tooth Designation system for tooth numbers. (01 - 32 for permanent teeth; A – T for deciduous teeth). (01 - 32 for permanent teeth; A – T for deciduous teeth). |
| 205 | Missing Tooth Number - After First Occurrence | Indicates the missing tooth number after the first occurrence. The values are based on the American Dental Association (ADA)'s Universal Numbering System/National Tooth Designation system for tooth numbers. (01 - 32 for permanent teeth; A – T for deciduous teeth). (01 - 32 for permanent teeth; A – T for deciduous teeth). |

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| **CPCDS Data Dictionary**  **Claim –Provider** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 94 | Claim Billing Provider NPI | The National Provider Identifier assigned to the Billing Provider. |
| 101 | Claim Billing Provider Contracting Status | Indicates that the Billing Provider has a contract with the Payer as of the effective date of service or admission. |
| 93 | Claim Attending Physician NPI | The National Provider Identifier assigned to the Attending Physician for the admission |
| 101 | Claim Site of Service Network Status | Indicates the network status of the site of service. |
| 99 | Claim Referring Physician NPI | The NPI of the referring physician. |
| 101 | Claim Referring Physician Network Status | Indicates the network status of the referring physician. |
| 95 | Claim Performing Provider NPI | The National Provider Identifier assigned to the Performing Provider. This is the lowest level of provider available (for example, if both individual and group are available, then the individual should be provided). |
| 101 | Claim Performing Provider Network Status | Indicates that the Performing Provider has a contract with the Plan (regardless of the network) that is effective on the date of service or admission. |
| 122 | Claim Prescribing Provider NPI | The identifier from NCPDP field # 411-DB (Prescriber ID) that identifies the National Provider Identifier (NPI) of the provider who prescribed the pharmaceutical. |
| 123 | Claim Prescriber Contracting Status | Indicates the network status of the prescribing physician. |
| 95, 96 | Claim PCP NPI | The identifier assigned to the PCP Provider. |
| 97 | Service Facility NPI | Service Facility Location information conveys the name, full address and identifier of the facility where services were rendered when that is different from the Billing / Performing Provider. Service Facility Location is not just an address nor is it a patient’s home. Examples of Service Facility Location include hospitals, nursing homes, laboratories or homeless shelter. Service Facility Location identifier is the facility’s Type 2 Organization NPI if they are a health care provider as defined under HIPAA. If the service facility is not assigned an NPI, this data element will not be populated. Reference CMS 1500 element 32a. |
| 165 | Care Team Role | The functional role of a provider on a claim. |
| 166 | Claim Attending Physician Name | The name of the Attending Physician for the admission |
| 167 | Claim Billing Provider Name | The name of the Billing Provider |
| 168 | Claim Performing Provider Name | The name of the Performing Provider. This is the lowest level of provider available (for example, if both individual and group are available, then the individual should be provided). |
| 169 | Claim PCP name | The name of the PCP Provider. |
| 170 | Service Facility Name | The name of the facility where the service occurred. Examples include hospitals, nursing homes, laboratories or homeless shelters.  Reference CMS 1500 element 32a. |
| 171 | Claim Referring Physician Name | The name of the referring physician. |
| 172 | Claim Prescribing Physician Name | The name of the provider who prescribed the pharmaceutical. |
| 173 | Claim Supervising Physician NPI | The National Provider Identifier assigned to the Supervising Physician for the admission |
| 174 | Claim Supervising Physician Name | The name of the Supervising Physician for the admission |
| 176 | Service Facility Address | The address of the facility where the service occurred. |
| 182 | Claim Operating Surgeon Name | The name of the operating surgeon. |
| 98 | Claim Operating NPI | The identifier assigned to the Operating Surgeon. |
| 185 | Practitioner Identifier Type | Identifies the type of identifiers for practitioners |
| 186 | Organization Identifier Type | Identifies the type of identifiers for organizations |

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| **CPCDS Data Dictionary**  **Claim Amounts** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 20 | Claim Total Submitted Amount | Amount submitted by the provider for reimbursement of health care services. This amount includes non-covered services. |
| 20 | Claim Total Allowed Amount | The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for non-contracted providers. Allowed amount should not include any COB adjustment. That is, the Allowed amount on a claim should be the same when the Plan is primary or secondary. |
| 20 | Amount Paid by Patient | The amount paid by the member at the point of service. |
| 20 | Claim Amount Paid to Provider | The amount paid to the provider. |
| 20 | Member Reimbursement | The amount paid to the member. |
| 20 | Claim Payment Amount | The amount sent to the payee from the health plan. This amount is to exclude any member cost sharing. It should include the total of member and provider payments. |
| 20 | Claim Non-covered Amount | The portion of the cost of this service that was deemed not eligible by the insurer because the service or member was not covered by the subscriber contract. |
| 20 | Member Paid Deductible | The portion of this service that the member must pay which is applied to the total period deductible. Deductibles are usually applied over a specific time period, such as per calendar year, per benefit period. |
| 20 | Co-insurance Liability Amount | The amount the insured individual pays, as a set percentage of the cost of covered medical services, as an out-of-pocket payment to the provider. Example: Insured pays 20% and the insurer pays 80%. |
| 20 | Copay Amount | Amount an insured individual pays directly to a provider at the time the services or supplies are rendered. Usually, a copay will be a fixed amount per service, such as $15.00 per office visit. |
| 20 | Member Liability | The amount of the member's liability. |
| 20 | Claim Other Payer Paid Amount | .  The reduction in the payment amount to reflect the current carrier as a secondary, teritary, etc, payer. May be multiple occurrences if the current carrier is a teritary, etc. carrier. |
| 20 | Claim Discount Amount | The amount of the discount. |

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| **CPCDS Data Dictionary**  **Claim Line** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 90, 118 | Service (from) Date | 90 - Date on which services began. UB04 (Form Locator 45).  118 - Date on which services began. Located on CMS 1500 (Form Locator 24A) |
| 36 | Line Number | Line identification number that represents the number assigned in a source system for identification and processing. |
| 119 | Service to Date | Date on which services ended. Located on CMS 1500 (Form Locator 24A) |
| 34 | Type of Service | High level classification of services into logical grouping. |
| 46 | Place of Service Code | Code indicating the location, such as inpatient, outpatient facility, office, or home health agency, where this service was performed. |
| 86 | Revenue Center Code | Code used on the UB-04 (Form Locator 42) to identify a specific accommodation, ancillary service, or billing calculation related to the service being billed. |
| 149 | Allowed Number of Units | The quantity of units, times, days, visits, services, or treatments allowed for the service described by the HCPCS code, revenue code or procedure code, submitted by the provider. |
| 38 | National Drug Code | National Drug Code (NDC), or if the prescription is a compound, the value 'Compound' |
| 78 | Compound Code | The code indicating whether or not the prescription is a compound. NCPDP field # 406-D6 |
| 39 | Quantity Dispensed | Quantity dispensed for the drug. |
| 151 | Quantity Qualifier Code | The unit of measurement for the drug. (gram, ml, etc.). |
| 142 | Benefit Payment Status | Indicates the in network or out of network payment status of the claim. |
| 92 | Line Payment Denial Code | Reason codes used to interpret the Non-Covered Amount that are provided to the Provider |
| 181 | Payment member explanation | Payment explanation to a member on an EOB |

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| **CPCDS Data Dictionary**  **Claim Line Amounts** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 20 | Line Noncovered Amount | Medical: The portion of the cost of this service that was deemed not eligible by the insurer because the service or member was not covered by the subscriber contract.  Pharmacy: Non-Covered Amount represents the NCPDP financial response field Amount Exceeding Periodic Benefit Maximum. |
| 20 | Line Member Reimbursement | The amount paid to the member. |
| 20 | Line Payment Amount | The amount sent to the payee from the health plan. This amount is to exclude any member cost sharing. It should include the total of member and provider payments. |
| 20 | Line Discount Amount | The amount of the discount. |
| 20 | Line Amount Paid by Patient | Medical: The amount paid by the member at the point of service.  Pharmacy: Amount that is calculated by the processor and returned to the pharmacy as the total amount to be paid by the patient to the pharmacy; the patient’s total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, etc |
| 20 | Drug Cost | Price paid for the drug excluding mfr discounts. It is the sum of the following components:ingredient cost, dispensing fee, sales tax, and vaccine administration fee. |
| 20 | Line Allowed Amount | The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for noncontracted providers. Allowed amount should not include any COB adjustment. That is, the Allowed amount on a claim should be the same when the Plan is primary or secondary. |
| 20 | Line Amount Paid to Provider | The amount paid to the provider. |
| 20 | Line Patient Deductible | The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for noncontracted providers. |
| 20 | Line Other Payer Paid Amount | The reduction in the payment amount to reflect the current carrier as a secondary, tertiary, etc, payer. May be multiple occurrences if the current carrier is a tertiary, etc. carrier. |
| 20 | Line Coinsurance Amount | Medical: The amount the insured individual pays, as a set percentage of the cost of covered medical services, as an out-of-pocket payment to the provider. Example: Insured pays 20% and the insurer pays 80%.  Pharmacy: Amount to be collected from a patient that is included in the Patient Pay Amount that is due to a per prescription copay or coinsurance. |
| 20 | Line Submitted Amount | Amount submitted by the provider for reimbursement of health care services. This amount includes non-covered services. |
| 20 | Line Allowed Amount | The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for noncontracted providers. Allowed amount should not include any COB adjustment. That is, the Allowed amount on a claim should be the same when the Plan is primary or secondary. |
| 20 | Line Member Liability | The amount of the member's liability. |
| 20 | Line Copay Amount | Medical: Amount an insured individual pays directly to a provider at the time the services or supplies are rendered. Usually, a copay will be a fixed amount per service, such as $15.00 per office visit.  Pharmacy: Amount to be collected from a patient that is included in the Patient Pay Amount that is due to a per prescription copay or coinsurance. |

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| **CPCDS Data Dictionary**  **Diagnosis** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 6, 7, 8, 21, 22, 23 | Diagnosis Code | 6 - ICD-9-CM code describing the condition chiefly responsible for a patient's admission to a facility. It may be different from the principal diagnosis, which is the diagnosis assigned after evaluation. (UB04 Form Locator 69). Decimals will be included.  7- Facility: The member's principal condition treated during this service. (UB04 Form Locator 67). This may or may not be different from the admitting diagnosis. Decimals will be included.  7 – Professional and Non-Physician: The member's principal condition treated during this service.  8 - Additional diagnosis identified for this member. Decimals will be included.  21- ICD-10-CM code describing the condition chiefly responsible for a patient's admission to a facility. It may be different from the principal diagnosis, which is the diagnosis assigned after evaluation. Decimals will be included.  22 - The member's principal condition treated during this service. This may or may not be different from the admitting diagnosis. Decimals will be included.  23 - Additional diagnosis identified for this member. Decimals will be included. |
| 30 | Is E code | This is any valid ICD-10 Diagnosis code in the range V00.\* through Y99.\* |
| 28, 29 | Present on Admission | Used to capture whether a diagnosis was present at time of a patient's admission. This is used to group diagnoses into the proper DRG for all claims involving inpatient admissions to general acute care facilities. |
| 21, 22, 23 | Diagnosis Code Type | 21- ICD-10-CM code describing the condition chiefly responsible for a patient's admission to a facility. It may be different from the principal diagnosis, which is the diagnosis assigned after evaluation. Decimals will be included.  22 - The member's principal condition treated during this service. This may or may not be different from the admitting diagnosis. Decimals will be included.  23 - Additional diagnosis identified for this member. Decimals will be included. |
| 21, 22, 23 | Diagnosis Type | 21- ICD-10-CM code describing the condition chiefly responsible for a patient's admission to a facility. It may be different from the principal diagnosis, which is the diagnosis assigned after evaluation. Decimals will be included.  22 - The member's principal condition treated during this service. This may or may not be different from the admitting diagnosis. Decimals will be included.  23 - Additional diagnosis identified for this member. Decimals will be included. |
| 189 | Diagnosis Code Type | Indicates if the diagnosis is admitting, principal, other, an external cause of injury or secondary |

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| **CPCDS Data Dictionary**  **Procedures** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| FAC IP – ICD PCS: 9, 11, 24, 26  FAC IP, OP– CPT / HCPCS / HIPPS: 40  Professional and Other – CPT / HCPCS: 40 | Procedure Code | 9 – Principal medical procedure a patient received during inpatient stay. Current coding methods include: International Classification of Diseases Surgical Procedures (ICD-9). Information located on UB04 (Form Locator 74).  11-Additional surgical procedure surgical (ICD-9) administered during inpatient stay.  24 –Principal medical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).  26 – Additional surgical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).  40 - Medical procedure a patient received from a health care provider. Current coding methods include: CPT-4 and HCFA Common Procedure Coding System Level II - (HCPCSII). Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) health insurers use to make payment determinations under several prospective payment systems. |
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| FAC IP – ICD: 9, 11, 24, 26 | Procedure Date | 9 – Principal medical procedure a patient received during inpatient stay. Current coding methods include: International Classification of Diseases Surgical Procedures (ICD-9). Information located on UB04 (Form Locator 74).  11- Additional surgical procedure surgical (ICD-9) administered during inpatient stay.  24- Principal medical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).  26 - Additional surgical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10). |
| FAC IP – ICD: 9, 11, 24, 26 | Procedure Code Type | 9 – Principal medical procedure a patient received during inpatient stay. Current coding methods include: International Classification of Diseases Surgical Procedures (ICD-9). Information located on UB04 (Form Locator 74).  11- Additional surgical procedure surgical (ICD-9) administered during inpatient stay.  24- Principal medical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).  26 - Additional surgical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10). |
| FAC IP – ICD: 9, 11, 24, 26 | Procedure Type | 26 - Additional surgical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10). |
| 41 | Modifier Code -1 | Modifier(s) for the procedure represented on this line. Identifies special circumstances related to the performance of the service. |
| 41 | Modifier Code -2 | Modifier(s) for the procedure represented on this line. Identifies special circumstances related to the performance of the service. |
| 41 | Modifier Code -3 | Modifier(s) for the procedure represented on this line. Identifies special circumstances related to the performance of the service. |
| 41 | Modifier Code -4 | Modifier(s) for the procedure represented on this line. Identifies special circumstances related to the performance of the service. |

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| **CPCDS Data Dictionary**  **Member** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 1 | Member ID | Identifier for a member assigned by the Payer. If members receive ID cards, that is the identifier that should be provided. |
| 70 | Date of Birth | Date of birth of the member. |
| 124 | Date of Death | Date of death of the member. |
| 124 | Deceased Flag | Date of death of the member. |
| 131 | Zip Code | This represents the member's 5 digit zip code. |
| 125 | County | The county for the member's primary address. |
| 126 | State | The state for the member's primary address. |
| 127 | Country | The country for the member's primary address. |
| 128 | Race Code | The race of the member. |
| 129 | Ethnicity | The ethnicity of the member. |
| 153 | Birth Sex | The gender of the member at birth. |
| 130 | Name | The name of the patient. |
| 71 | Gender Code | Gender of the member. |
| 184 | Patient Identifier Type | Identifies the type of identifier payers and providers assign to patients |
| 191 | Unique Member ID | Unique identifier for a member assigned by the Payer. |
| 192 | City | The city for the member's primary address |
| 193 | Member Address Begin / End Dates | The start / end date of the time period for which the member's address information applies. |

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| **CPCDS Data Dictionary**  **Coverage** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 132 | Subscriber ID | The identifier assigned by the Payer on the subscriber's ID card. |
| 3 | Coverage Type | Identifies if the coverage is PPO, HMO, POS, etc. |
| 133 | Coverage Status | Identifies the status of the coverage information (default: active). |
| 74 | Start Date | Date that the contract became effective. |
| 75 | End Date | Date that the contract was terminated or coverage changed |
| 134 | Group ID | Employer account identifier. |
| 135 | Group Name | Name of the Employer Account. |
| 154 | Plan Identifier | Business concept used by a health plan to describe its benefit offerings. |
| 155 | Plan Name | Name of the health plan benefit offering assigned to the Plan Identifier. |
| 2 | Payer Identifier | Issuer of the Policy |
| 141 | Other Payer Name(s) | Identifies another payer who applied benefits for the service on another claim. |
| 72 | Relationship to Subscriber | Relationship of the member to the person insured (subscriber). |
| 175 | Claim payer Name | Name of the payer responsible for the claim |

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| **CPCDS Data Dictionary**  **Metadata** | | |
| **Map ID** | **CPCDS Element** | **Description** |
| 163 | EOB Last Updated Date | Defines the date the Resource was created or updated, whichever comes last |
| 163 | Coverage Last Updated Date | Defines the date the coverage that was effective as of the date of service or admission was created or updated, whichever is later. |
| 163 | Member Demographics Last Updated Date | Defines the date the member demographics were updated |
| 163 | Practitioner Demographics Last Updated Date | Defines the date the practitioner's demographics were updated |
| 163 | Organization's Demographics Last Updated Date | Defines the date the organization's demographics were updated |
| 190 | EOB Profile | Profile this resource claims to conform to |
| 190 | Coverage Profile | Profile this resource claims to conform to |
| 190 | Patient Profile | Profile this resource claims to conform to |
| 190 | Practitioner Profile | Profile this resource claims to conform to |
| 190 | Organization Profile | Profile this resource claims to conform to |