Table 3: MMP Provider Payment Requests (M_Claims) Record Layout

- Include all requests to the MMP processed as both contract and non-contract provider denied claims and paid claims from non-contract providers only.
- Exclude all requests processed as direct member reimbursements, dismissals, duplicate claims and payment adjustments to claims, reopenings, claims denied for invalid billing codes, denied claims for members who are not enrolled on the date of service, claims denied due to recoupment of payment. Submit provider payment requests (claims) based on the date the claim was paid or denied, or should have been paid or denied (the date the request was initiated may fall outside of the review period).
- If a claim has more than one line item, include all of the claim's line items in a single row and enter the multiple line items as a single claim.

Column ID	Field Name	Field Type	Field Length	Description
A	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated claim or payment request number assigned by the MMP for this request. If a claim or payment request number is not available, please provide your internal tracking or case number. Answer NA if there is no claim, payment request or other tracking number available.
G	Provider Type	CHAR Always Required	3	Indicate whether the provider who performed the service is a contract provider (CP) or non-contract provider (NCP). Note, the term "provider" encompasses physicians and facilities.
H	Is this a clean claim?	CHAR Always Required	2	Yes/No indicator flag to indicate whether the claim is clean (Y) or unclean (N). Answer NA for untimely requests that are still open or if clean status has not been determined.

Column ID	Field Name	Field Type	Field Length	Description
I	Date the request was received	CHAR Always Required	10	Provide the date the payment request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
J	Diagnosis	CHAR Always Required	100	Provide the member diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC).
K	Type of service	CHAR Always Required	50	Enter "BH" for behavioral health services, "LTSS" for long term services and supports, "SU" for substance use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.
L	Issue description	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the claim was denied.
M	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. MMPs should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
N	Date the claim was paid or denied	CHAR Always Required	10	Date the claim was paid. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer DENIED for claims that were denied. Answer NA for untimely cases that are still open.
O	Was interest paid on the claim?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether interest was paid on the claim.
P	Was the request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.
Q	Date written notification provided to member	CHAR Always Required	10	Date written notification provided to member. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer Pending if written notification has not yet been provided, but is anticipated to be provided in a forthcoming EOB or IDN notice. Answer NA if no written notification provided to the member.

Column ID	Field Name	Field Type	Field Length	Description
R	Date written notification provided to provider	CHAR Always Required	10	Date written notification provided to the provider. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA if no written notification was provided.
S	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the claim (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.