CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 29 **Date: NOVEMBER 7, 2003**

CHANGE REQUEST 2961

I. SUMMARY OF CHANGES: CMS has decided to streamline the claims crossover process to better serve our customers. Medicare complementary insurers (i.e., non-Medigap plans), Title XIX State Medicaid Agencies, and Medigap plans—collectively known as coordination of benefit (COB) trading partners—that are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability will no longer have to sign separate agreements with individual Medicare contractors. Each COB trading partner will now enter into one national Coordination of Benefits Agreement (COBA) with CMS' consolidated claims crossover contractor, the Coordination of Benefits Contractor (COBC). Likewise, each COB trading partner will no longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers nor receive numerous crossover files. The COBC shall be designated to collect crossover fees from all COB trading partners (except for Title XIX State Medicaid Agencies which are exempt from such fees) on behalf of CMS. Sections will either need to be added or revised within the Medicare Claims Processing Manual to capture the scope of the many changes that will result from the claims crossover consolidation process. This will be accomplished shortly through a separate Change Request.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004
***IMPLEMENTATION DATE: January 5, 2004**

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED –

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
	Manual Instructions
	Confidential Requirements
	One-Time Special Notification

Business Requirements

Pub. 100-04	Transmittal: 29	Date: November 7, 2003	Change Request 2961

I. GENERAL INFORMATION

A. Background: This instruction revises transmittal number AB-03-125 in terms of Business Requirements 1 through 8. Also, through this instruction Attachment C of AB-03-125 becomes Attachment B of this instruction. Attachment B from AB-03-125 has been deleted.

CMS has decided to streamline the claims crossover process to better serve our customers. Insurer entities that are eligible to receive Medicare paid claims data directly from CMS for purposes of calculating their secondary liability will no longer have to sign separate agreements with individual Medicare intermediaries and carriers. Likewise, they will not need to prepare and send separate eligibility files that include eligibility information for each insured beneficiary to individual contractors nor receive numerous claims crossover files. The effort to consolidate the claims crossover function will be implemented via a phased-in approach. **Phase I** of this transmittal will include analysis, design and programmer coding for the January 2004 system release. **Phase II** of this transmittal will include testing and address any additional programmer coding or other specifications necessary as a result of testing. **Phase II** will be completed with the April 2004 system release. **Phase III** (future instructions) will include the claim-based crossover and recovery of claims processes.

B. Policy: Insurer entities will be transitioned from the current trading partner agreement process to new agreements called Coordination of Benefits Agreements (COBA). These agreements will be entered into directly between CMS and the COBA partners. These agreements will be negotiated by the Coordination of Benefits Contractor (COBC) and will provide for each COBA partner to send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the COBC. The COBC will transmit the beneficiary eligibility files to CWF via the maintenance transaction specified in Attachment A (Common Working File [CWF] requirements for establishing a Beneficiary Other Insurance [BOI] record, which was previously implemented). When CWF receives claims with service dates that fall between the effective and termination dates of one or more BOI records, a BOI trailer (Attachment B) will be generated/attached to the basic claim reply record containing other Medigap or non-Medigap insurance information.

C. Provider Education: Contractors will be required to inform affected provider/supplier communities of the forthcoming consolidation of the claims crossover process. See Business Requirement 10, below, for further details.

II. BUSINESS REQUIREMENTS

****NOTE:** APASS is waived from implementation of these requirements in light of the completion of the transition of APASS users to FISS by May 2004.

Requirement #	Requirements	Responsibility
Ch. 28, Sec. 70.6 Requirement 1	You shall send Medigap and non-Medigap claim information to the COBC for crossover to a COBA trading partner in response to the receipt of a CWF Beneficiary Other Insurance (BOI) trailer that includes a COBA identification number (ID). You shall not send duplicate claims submitted by a provider or supplier that have been previously adjudicated.	Intermediaries and Carriers

	You will not receive copies of the COBA Insurance File to perform crossover claim selection criteria, as previously indicated in AB-03-125 (CR 2836). The COBC will perform crossover claim selection criteria for COBA trading partners upon receipt of an 837 v4010A1 flat file and National Council for Pharmacy Drug Programs (NCPDP) file from you and will, subject to the terms of signed COBAs, either cross or suppress claims from the outbound crossover file. (See requirement 4, below, for additional information regarding the flat file transmission process.)	
Ch. 27, Sec. 80.14 & Ch. 28, Sec. 70.6 Requirement 2	Receipt of a BOI reply trailer indicates that a trading partner has signed a COBA. When a BOI reply trailer is received, the COBA ID will identify the type of crossover (see data element 24, Attachment A). Although each COBA ID will consist of a five-digit prefix that will be all zeroes, you are responsible only for picking up the last five digits within these ranges, which will be right justified in the COBA number field. As provided by Requirement 6, below, trading partners will be asked to cancel eligibility files that they have with you once they have signed COBAs with the COBC. You shall cease the use of those files upon notification of cancellation. You shall contact the trading partner when you have identified a situation where that entity has not cancelled eligibility files and you are receiving confirmation of a COBA for crossover to the same insurer.	Intermediaries and Carriers
Ch. 28, Sec. 70.6 Requirement 3	In those circumstances where you receive a BOI trailer and some other indication of crossover eligibility, e.g., Medigap or Medicaid information is supplied on the claim, use the following rules: 1. If a BOI trailer with a COBA ID that falls in the Medigap range is received **and** Medigap crossover information is also received on the claim, you should not cross over the claim-based Medigap. Instead, send the claim to the COBC (based on receipt of a COBA ID) on the 837 v4010A1 flat file or NCPDP file, as applicable, for crossover by the COBC to the COBA trading partner. (**Note:** The assumption is that a beneficiary will have only one true Medigap insurer.) When a BOI trailer is received as described in the situation above, Medicare carriers shall assume that the beneficiary has purchased a Medigap	Intermediaries and Carriers (**Note:** Claim-based scenarios only apply to carriers.)

	policy with an automatic crossover feature. Therefore, if the privacy release indicator on the claim specifies that the beneficiary has not given authorization to cross the claim, and a BOI trailer with a Medigap COBA ID is received, the privacy release indicator shall be ignored. 2. If a BOI trailer is received with a COBA ID that falls in the Medicaid range **and** Medicaid crossover information is also received on the claim, you should not cross over the claim-based Medicaid. Instead, send claims to the COBC (based on receipt of a COBA ID) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner. You shall not change your current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance, including, for example, supplemental or Medigap insurers identified by a BOI trailer COBA ID. 3. If you receive a COBA ID on the BOI trailer that falls in the supplemental range and you have an active trading partner agreement/eligibility file for that beneficiary, you shall transmit the claim to the COBC for crossover to the COBA trading partner **and** cross the claim to your current trading partner. 4. If you receive a COBA ID on the BOI trailer that falls in the supplemental range and you also receive Medigap crossover information on the claim, you shall cross the claim to the Medigap insurer identified on the claim **and** transmit the claim to the COBC for crossover to the COBA trading partner based on the COBA ID. CMS will provide generic Medicare Summary Notice (MSN) and Remittance Advice (RA) messages for claims transmitted to the COBC for crossover purposes. This will occur via a separate instruction.	CMS
Ch. 28, Sec. 70.6 Requirement 4	You shall transmit all non-NCPDP claims received with a COBA ID on the BOI trailer to the COBC in an 837 v4010A1 flat file**,** as described in Transmittal AB-03-060. In a separate transmission, send the claims received in the NCPDP file format	Intermediaries and Carriers

	to the COBC in that same format. You shall enter the COBA ID in the l000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, you shall send a separate 837 or NCPDP transaction to the COBC for each COBA ID. You shall perform the transmission at the end of the regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare final payment. Transmission should occur via Network Data Mover (NDM) over AGNS (AT&T Global Network Services). Refer to Attachment C for a listing of your specific responsibilities for populating the 837 flat files that you will send to the COBC. To assist the COBC in resolving any file transmission or other related problems, each contractor shall provide a technical contact (i.e., contractor name, contact name, telephone number, and e-mail address) to the COBC**.** Each contractor shall send its technical contact information to Brian Pabst at CMS (bpabst@cms.hhs.gov) no later than January 1, 2004.	
Ch. 28, Sec. 70.6 Requirement 5	Upon receipt of the transmitted claims, the COBC shall initially edit the file and return a response file via NDM to the contractors indicating the number of claims received and an indication of whether the entire file was accepted or rejected. When you receive the reject indicator "R" via the Claims Response File, you are to retransmit the entire file to the COBC. If you receive an acceptance indicator "A," this confirms that your entire COB flat file or NCPDP file transmission was accepted. Refer to Attachment D for a copy of the Claims Response File Layout (80 bytes). Note that if you submit claim files daily, the COBC will return claim response files to you daily. COBC anticipates assigning the following file names to claims response files returned to Medicare contractors. These file names will be created as part of the NDM set-up process. As COBC will potentially receive 3 types of files, a separate response will be generated for each file: PCOB.BA.NDM.COBA.Cxxxx.PARTA(0) PCOB.BA.NDM.COBA.Cxxxx.PARTB(0) PCOB.BA.NDM.COBA.Cxxxx.NCPDP(0).	COBC

	Note that "xxxxx" denotes the Medicare contractor number. Test files will be prefixed with "TCOB" instead of "PCOB." Once files have been retransmitted to the COBC and any associated problems resolved, the COBC shall subject the claims received to the claims selection criteria, as specified in each trading partner's signed COBA. Based upon those criteria, a beneficiary's claim will either be included on or suppressed from the outbound crossover file. The COBC shall suppress non-assigned claims from crossover to Medicaid. The COBC shall apply Medicaid suppression logic as defined in the COBA. The COBC shall maintain files transmitted to COBA trading partners on line for 20 business days from the date of transmission.	
Ch. 28, Sec. 70.6 Requirement 6	You shall keep your present crossover process in place, including invoicing for claims crossed to current trading partners, until each of your present trading partners has been transitioned to COBA. As trading partners are signed on to national COBAs, they will be advised that it is the trading partners' responsibility to simultaneously cancel current agreements with you and to cease submission of eligibility files to you. The CMS expects to complete the transition of current eligibility-based trading partners to COBAs by October 1, 2004.	Intermediaries and Carriers
Ch. 28, Sec. 70.6 Requirement 7	On or after January 1, 2004, you shall refer insurers willing to negotiate crossover agreements to COBC at 1-800-999-1118. Prior to January 1, 2004, you may refer insurers interested in renewing a Trading Partner Agreement (TPA), entering into a new agreement, or obtaining information regarding the COBA process to COBC's technical consultant (Ms. Razor) at 716-434-2892.	Intermediaries and Carriers
Ch. 28, Sec.70.6 Requirement 8	Your customer service personnel shall answer provider/supplier and beneficiary questions about an individual's crossover status by referring to the beneficiary BOI screens on the Health Insurance Master Record (HIMR). You shall access information regarding the crossing of a specific claim by referring to claims history on HIMR. (CMS is developing another process to modify	Intermediaries and Carriers

	HIMR so that a claims crossover disposition indicator will be displayed to assist with customer service inquiries. See Change Request 2962 for more details.) The COBC shall answer COBA trading partner questions regarding all aspects of the COBA and trading partner file transmission issues.	 COBC
Ch. 28, Sec. 70.6 Requirement 9	For workload reporting, you shall provide separate counts, by trading partner, for claims you cross to current trading partners (including Medicaid), as you currently report. You shall track claims transmitted to the COBC for crossover to COBA trading partners for future reporting requirements by COBA ID.	Intermediaries and Carriers
Requirement 10	You shall inform affected provider/supplier communities of the forthcoming consolidation of the claims crossover process by posting either a summary or relevant portions of this instruction on your Web site within two weeks of the issuance date of this instruction. In addition, this same information shall be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider/supplier communities, you must use it to notify subscribers that information about consolidation of the claims crossover process is available on your Web site.	Intermediaries and Carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
1	COBC shall accumulate claim files from all intermediaries and carriers and consolidate them into one Part A, one Part B, and one NCPDP file per COBA Agreement.
2	COBC shall send crossed claims to trading partners on a timeframe defined in the COBA Agreement.
3	CMS shall arrange for the invoicing of COBA partners for crossover fees.
4	COBC shall transmit a weekly claims extract file to CWF to update each claim's crossover disposition status.

B. Design Considerations: NA

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: NA

D. Contractor Financial Reporting /Workload Impact: NA

E. Dependencies: NA

F. Testing Considerations: NA

IV. OTHER CHANGES

Citation	Change

SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2004 **Implementation Date:** January 5, 2004 **Pre-Implementation Contact(s):** Harry Gamble (410-786-5787) and Donna Kettish (410-786-5462) **Post-Implementation Contact(s):** Donna Kettish (410-786-5462) and Brian Pabst (410-786-2487)	**These instructions should be implemented within your current operating budget.**

3 Attachments

Attachment A

Common Working File (CWF) Beneficiary Other Insurance (BOI) Auxiliary (aux) File

The BOI aux file will contain information about other insurance that a beneficiary has that pays after Medicare. The BOI aux file is needed in the CWF to store information about other insurance that beneficiaries have, accept changes to the information from the COB Contractor (COBC), and provide the means for delivering the information with the claims reply to intermediaries and carriers.

The CWF maintainer will:

- Develop the capability to allow the BOI aux file to accept maintenance transactions containing changes, additions, and deletions, from the COBC. The file will allow for up to 40 occurrences of other insurer types;
- Develop consistency edits for the maintenance transactions;
- Add the number 11120 to the CWF table of contractor numbers to identify the COBC as the submitter of BOI maintenance transactions;
- Create the CWF BOI aux file that will contain other insurer information for each beneficiary. The required data elements are listed in the attachment;
- Create a trailer, containing insurer information that pays after Medicare, that will be attached to a basic claim reply record to be sent to the intermediaries and carriers;
- Develop a HIMR screen to be used by intermediaries and carriers to provide customer service and conduct research on crossovers to a beneficiary's other insurer;
- Document the BOI aux file, including the user's guide for CWF hosts, intermediaries, and carriers; and
- Release the BOI aux files to the CWF hosts for installation. Data are not available to load at this time.

Data Elements Required for the BOI Aux File Record

DATA ELEMENT	REMARKS
1. Record Type	CWF BOI other insurer maintenance (**Mandatory)**
2. Health Insurance Claim (HIC) Number	Beneficiary's HIC/Railroad Board number (**Mandatory)**
3. Beneficiary's Surname	Beneficiary's surname (**Mandatory)**
4. Beneficiary's First Initial	Initial of first name of beneficiary (**Mandatory)**
5. Beneficiary's Date of Birth	Beneficiary's date of birth (CCYYMMDD)
6. Beneficiary's Sex Code	Beneficiary's sex code 0 = Unknown 1 = Male 2 = Female
7. Contractor Number	Identifies COB contractor applying maintenance
8. Creation Date	Date record created (CCYYMMDD)
9. Deletion Date	Date record deleted (CCYYMMDD)
10. Document control	Document control number
11. Action Type	Identifies type of maintenance (**Mandatory)** 0 = Add insurance data transaction 1 = Change insurance data transaction 2 = Delete insurance data transaction
12. Update Indicator	Date maintenance applied (CCYYMMDD)
13. Insurance Code	Insurance coverage type (**Mandatory)** A = Supplemental B = TRICARE C = Medicaid
14. Insurer's Name	Insurer's name
15. Insurer's Address - 1	Insurer's address line 1
16. Insurer's Address – 2	Insurer's address line 2
17. Insurer's City	Insurer's city
18. Insurer's State	Insurer's State

DATA ELEMENT	REMARKS
19. Insurer's Zip Code	Insurer's zip code
20. Policy Number	Insurer's policy number of insured
21. Insurance Effective Date	Effective date of insurance coverage (CCYYMMDD) (One or more occurrences) (**Mandatory)**
22. Insurance Termination Date	Termination date of insurance coverage (CCYYMMDD) (One or more occurrences) (**Mandatory, if applicable)**
23. Identifier Number Assigned by Supplemental Insurer	Number assigned to insured by supplemental insurer
24. Coordination of Benefits Agreement (COBA) number	COBA number assigned to other insurer's agreement by COB contractor/numbers will be right justified and will fall into these ranges based on type of COBA trading partner: Supplemental 00001-29999 Medigap 30000-59999 TRICARE 60000-69999 Medicaid 70000-79999 Others 80000-89999 Unassigned 90000-99999 (**Mandatory)**
25. NPlanID	The CMS national plan identifier assigned to the insurer (**Mandatory when available)**
26. Other Insurer Number	Other number assigned to an insurer by an FI or carrier under a former trading partner agreement (One or more occurrences)

CWF BOI Trailer Requirements Attachment B

Requirement 9
CWF must create a new Trailer '29'. Trailer '29' will display the following:

Trailer Format: CUTELX29

```
01  HUBO-TRAILER.
    05  HUBO-TRLR-CODE                PIC  9(02).
    05  HUBO-TRLR-OCCURENCES          PIC  9(02).

    05  HUBO-TRAILER-DATA             OCCURS 1 T0 10 TIMES
                                  DEPENDING HUBO-TRLR-OCCURENCES
                                  INDEXED   HUBO-TRLR-INDEX.
       1O HUBO-COBA-NUMBER           PIC  X(10).
```

Requirement 10 (THE NEW '29' TRAILER WILL ONLY BE RECEIVED IN CWF TESTING AT THIS TIME)

The '29' Trailer will be returned only when the HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC record receives an ' 01' disposition **(i.e., adjudicated claim, including denials)**, and the Beneficiary has a BOI Auxiliary file.

CWF will return the '29' Trailer after the BOI Auxiliary file is searched, and an occurrence is found with an open Effective Date that matches the Date of Service of the incoming record.

CWF will also return the '29' Trailer after the BOI Auxiliary file is searched, and an occurrence is found with an Effective and Termination Date, and the Date of Service of the incoming record is within the date spans of the BOI occurrences.

Requirement 11 identifies what will be returned on the BOI trailer.
Requirement 11 (THE NEW TRAILER MASK THAT REFLECTS THE '29' TRAILER WILL ONLY DISPLAY IN CWF TESTING AT THIS TIME)

REPORT: FFCHG020 FREEFORM TEXT

CWF will display the applicable number of occurrences from the BOI Auxiliary file in the CWF Response File Trailer Mask. A maximum of ten '29' Trailers will be displayed.

837 COB Flat File Creation and Submission Process Rules

Attachment C

Part B and DMERC (Professional)

1. The following segments shall not be passed to the COBC:
    a) ISA (Interchange Control Header Segment)
    b) IEA (Interchange Control Trailer Segment)
    c) GS (Functional Group Header Segment)
    d) GE (Functional Group Trailer Segment)

2. The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:
    a) NM103—Use spaces.
    b) NM109—Include COBA ID.

3. The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows, with COBC completing any missing information:
    a) NM1 segment—For NM103, NM104, NM105, and NM107, use spaces.
    b) NM1 segment—For NM109, include HICN.
    c) N3 segment—Use all spaces
    d) N4 segment—Use all spaces.

4. The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard systems, the NM1, N3, and N4 segments should be formatted as follows, with COBC completing any missing information:
    a) NM1 segment—For NM103, use spaces.
    b) NM1 segment—For NM109, include the COBA ID.
    c) N3 segment—Use all spaces.
    d) N4 segment—Use all spaces.

5. The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs

will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

a) NM103—Use spaces.
b) NM109—Include COBA ID.

6. The 2320 loop lists other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly. COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. If unknown, spaces may be used.
   a) SBR01—Treat as you currently do.

Part A (Institutional)

1. As the ISA, IEA, and GS segments are included in the '001' record with other required segments, the '001' record must be passed to the COBC. However, as the values for these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.

2. The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover trading partner information will be unknown to the standard systems, the following fields should be formatted as follows for the NM1 segment on the '001' record:
   a) NM103—Use spaces.
   b) NM109—Include COBA ID.

3. The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows for the '300' record, with COBC completing any missing information:
   a) NM1 segment – For NM103, NM104, NM105, and NM107, use spaces.
   b) NM1 segment—For NM109, include HICN.
   c) N3 segment—Use all spaces.
   d) N4 segment—Use all spaces.

4. The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the '300' record, with COBC completing any missing information:

a) NM1 segment—For NM103, use spaces.
b) NM1 segment—For NM109, include COBA ID.
c) N3 segment—Use all spaces.
d) N4 segment—Use all spaces.

5. The 2330B loop of the '575' record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:
   a) NM103—Use spaces.
   b) NM109—Include COBA ID.

6. The 2320 loop lists other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly. COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. If unknown, spaces may be used.
   a) SBR01—Treat as you currently do.

ATTACHMENT D

Claims Response File Layout (80 bytes)				
Field	***Name***	***Size***	***Displacement***	***Description***
1.	Contractor Number	5	1-5	Contractor Identification Number
2.	Transaction Set Control Number/Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the ANSI 837 flat file or in field 806-5C from the batch header of the NCPDP file.
3.	Number of claims	9	15-23	Number of Claims contained in the ANSI 837 flat file or NCPDP file. This is a numeric field that will be right justified and zero-filled.
4.	Receipt Date	8	24-31	Receipt Date of ANSI 837 flat file or NCPDP file in CCYYMMDD format
5.	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the ANSI 837 flat file or NCPDP file. Values will either be an “A” for accepted or “R” for rejected.
6.	Filler	48	33-80	Spaces